WORKING WITH OLDER PEOPLE: A Guide to Practice

Volume II: Human Services

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Volume II: Human Services

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Overview

Volume I contained an overview of the processes of aging. In that volume, we set the stage for an examination of the integrated service needs of the older population. We stress integrated because many individuals sooner or later need a variety of services or a contingency plan for the potential use of these services. In this volume, we assume that human services should be available in a continuum paralleling a continuum of needs. However, it is rare that we can find a single agency or source to provide services meeting the entire continuum of needs. In some communities there is not continuum of services; in others, the continuum is primitive; while in still others there will be large or small gaps. In some instances, there may be inadequacies of manpower and services. Gerontologic practitioners and planners will find that even where there is a continuum of services that is well developed, there are prominent administrative "seams" where one agency leaves off and the next one begins. People tend to be lost in these "seams." These "seams" require some coordinative "ironing out" lest they become hurdles to timely care-giving. Chapter I provides practitioners and planners with information on manpower needs and manpower realities.

This volume also seeks to help practitioners and planners to locate themselves in relation to the continua of needs and services. If we understand the long-range goal of providing a complete service continuum, it may help us in learning about the steps to take in specific communities for realizing the ideal programs. Short-range goals may include the development of an information-gathering system for planning purposes. We need to know--Who are the elderly in the community? How are they clustered in relation to services? What can the community offer now and later? Such information must be evaluated making sure that sufficient data are available

to help us in building sound tactics and strategies. We need also to test periodically whether our concepts and programs are realistic and adequate for meeting the major needs of the client population. The evaluation of agency performance requires data on whether the provided services resulted in improvements in the functioning of clients or in the prevention of further declines in functioning. Chapter II examines the concepts of continua of services and needs and responsive strategies for developing services and meeting needs.

In Chapter II, we described four target groups: the unimpaired, the minimally impaired, the moderately impaired, and the severely impaired. We described their needs and special assessment foci. Each group is defined in terms of degree of ability to live independently. An understanding of these categories may sensitize practitioners and planners to the scope and intensity of needs of individuals and populations of individuals. Such needs as health, social service, enrichment, and others vary according to degree of impairment. We try to visualize the context of impairment through case examples as well as general discussions.

While Chapter III focuses on the continuum of need, Chapter IV focuses on the continuum of services, describing types of services applicable to individuals in the categories of impairment. Although much of the material is necessarily overlapping, it is important to examine the reciprocal perspectives.

In conclusion, we sum up and attempt to interrelate the values of research, program evaluation, and program application. We stress the necessity of involving the elderly themselves in the processes of program evaluation and development.

As practitioners or planners, many of the older people you will meet with will be persons in need of help with only a few problems, not an entire spectrum of problems. We can be grateful that this is so, for otherwise the demand for services would be unfathomable. More than that, it would mean that the elderly are a passive population. This is not the case either in terms of individuals or groups. But what must be recognized is that some services--often of the simplest kind--are powerful catalysts of independent living. Frequently if one small but key problem can be resolved the individual is then able to cope with many other problems independently. For example, an individual with a minimal impairment such as difficulty in walking the whole distance to a market, may become a crisis patient if the result of this inability is an inadequate diet. A transportation link such as an escort or a meals-on-wheels service may spell the difference between being able to cope with life at home and having to be institutionalized. Single services which may relieve major problems for individuals include financial aid, health services, senior centers, day care centers, homemaker services, counseling and guidance, chore services, foster homes, congregate meals, and congregate housing.

Before any services can be brought into play, however, each individual situation must be assessed comprehensively. In Chapter III, a needs assessment and discussion is undertaken for people in each of the four categories discussed in the earlier chapters. The catalyst service may often be identified readily with adequate assessment. This service may go unnoticed when the assessment is hit or miss or otherwise inadequate. Assessment is the bridge between the continuum of need and the continuum of services.

A great deal in this volume has been written about comprehensive assessment, and therefore we are giving a brief definition of what we mean by this expression. The heart of what should be assessed is an individual's ability to function as an independent adult, especially with respect to the activities of daily living (grooming, toileting, preparation of meals), health or physical disability status, ability to provide for one's psychosocial needs. Comprehensive assessment goes beyond functional assessment. It looks at all aspects of the individual's needs. For example, the person with visual problems may need, in addition to glasses, changes in the physical arrangements of his or her home in order to prevent accidents and to facilitate mobility, a hot-line telephone number in case of trouble, and a periodic medical screening. An assessment-based plan would also include opportunities for the individual to take part in community activities, thus preventing social isolation by providing opportunities for interaction with others.

Enough is known about the health trajectories or patterns of health maintenance and decline that preventive steps can be taken in time for many individuals. The individual experiencing increasing difficulties in maintaining a home alone may need counseling and planning for relocation to a congregate housing project in which a variety of supportive services are offered. The alternative to such counseling and planning may be a crisis in which the individual must be institutionalized, perhaps for only a short time or perhaps for life. We cannot stress enough the need for practitioners and planners to be aware of individuals' needs and the available community services in order that timely cross- and multiple-referrals and actions are provided to people by agencies in cooperation with one another.

This does not mean that disabled elderly individuals cannot lead satisfying lives. They can--often precisely because supportive services on a continuing or occasional basis are available either from agencies or, perhaps more importantly, from friends, relatives, and neighbors. In fact, in assessing and/or planning for people, the availability of the informal network of helpers is one of the most crucial facts to establish. Some individuals with severe health problems continue living at home because of these supports, while others in the same condition must be institutionalized because the supports are lacking.

When the individual requires addmission to a nursing home, attention must be given to psychosocial as well as physical needs. For example, the application of milieu therapy to maintain or restore the individual's mental health or social orientation can be an essential element of institutional care. The objective in milieu therapy is to create a total environment designed to enhance an individual's capabilities. This technique often requires staff training in the area of developing psychosocial support. Without such intervention, the individual patient may lose a sense of self-worth or retreat to passive dependence.

Another important consideration in providing institutional care is the design in modification of the physical environment so that it is barrier-free, pleasant, and supportive of self-care. In addition, by permitting residents to furnish their rooms with personal effects and by providing activity centers in institutions, the individual's feelings of self-worth can be enhanced.

We emphasize the unique needs of an individual in developing plans of care in the community. This emphasis on the individual should dominate care in the institution. The assessment process must be concerned with

placing the individual in the appropriate facility or portion of the facility or portion of the facility in which care is given at the correct level. Such care may be intensive and skilled or personal and of limited nature. It can be provided in a skilled nursing facility, intermediate care facility, or through personal care at home. As the result of a growing movement, the hospice is also available for terminal care. The hospice provides physical and emotional comfort to the dying patient as well as support to the surviving family members and friends.

In the future, as supportive services are improved in quality and distribution, more and more elderly persons will be able to remain in their own homes for longer periods of time. Contributing to this prospect--which will also be a challenge to practitioners and planners--will be advances in the prevention, cure, and management of chronic illnesses. As a result of improved medical care and social change, future generations will probably reach old age in better financial, psychosocial, and physical health. It is, therefore, important to keep in mind the changing needs of changing populations as we plan and provide services for the older population.

It is for this reason, therefore, that Volume II must be placed in historical context. As this material is going to press, the Older Americans Act is being revised. Undoubtedly, other legislation affecting older people will be passed and current legislation modified. Consequently, ten years from now these two volumes will need to be revised in the light of changing knowledge and conditions just as the earlier volumes needed revision. As our society evolves, many of today's major problems will recede and new ones develop. Practitioners and planners whose concerns are with the older population find their work with older people far from a monotonous activity,

primarily because of the constant changes which are going on. Certainly, the contributors to this volume have not found such work monotonous.

If we look into a crystal ball, we see gaps in services, gaps that surely will be filled during the coming decade. These gaps have their corresponding opportunities for manpower development and careers. The interrelated physical health, mental health, social and other needs of the elderly require the development of personnel and facilities for providing multi-disciplinary assessments, for preparing individual plans for care, and for helping to carry them out in community and institutional context. We already see, in a few places around the country, the emergency of geriatric or gerontological assessment units and an emphasis on area agencies on aging as coordinating elements for meeting housing, transportation, health, and other needs of the older population.

Our crystal ball also suggests that trends in development of programs to aid the older population in independent living and in institutions are likely to intensify. It has been well over a decade since the Older Americans Act became law. It has also been over a decade since the passage of Medicare and Medicaid. As we have already noted, these statutes have been amended and expanded and in the continual process of further modification. Likewise, income maintenance through the Social Security System is enlarging, although not without financial difficulties.

The legislative focus most recently has been on the coverage of so-called "alternative" modes of care, that is, alternatives to institutional care. More to the point, perhaps, are the terms "alternatives to inappropriate institutional care" or "options in long-term care ." (One hears occasionally on Capitol Hill a wry comment that the <u>institution</u> should be considered the alternative site of care, the home and comunity being

primary.) Home-health services, homemaker services, and adult day care are among the "alternatives" in the legislative limelight. There are also congregate housing for the elderly and handicapped, rental assistance, and other efforts in the housing field that have received heavy federal support. One can see a growing demand for programs to help the elderly homeowner meet rising property taxes, utility expenses, and maintenance costs. Home-delivered services to the elderly homeowner or elderly resident of a housing project are surely on the increase.

In transportation, the federal government is subsidizing the efforts of nonprofit entities to provide specialized services for the elderly and to improve mass transit systems so that they are more useful to older people. In some areas, bus fares for the elderly are reduced or free, while taxi fares are subsidized. Other programs which have captured the imagination of legislators and others in public life are sharing legal representation for the elderly, developing their educational opportunities, and eliminating architectural barriers. We expect that these concerns will continue to find expression in the creation of financing of services and the manpower to staff them.

While our crystal ball does not tell us with certainty, it appears that our attitudes toward old age and older people are becoming less negative and increasingly people recognize that the second half of life can have many positive aspects.

Another area in which there is a need for services is that of pre-retirement planning. We use "pre-retirement" to mean the entire period before leaving the work force, covering the adolescent and the young and middle-aged populations. Pre-retirement planning will help people to become better prepared and informed about retirement options in terms of

financial needs, health maintenance, interpersonal relationships, leisure, and environmental needs.

There is a need for sensitive professionals and pre-professionals to work with older people. Such work requires skills of varying kinds, including the ability to cooperate with various types of human service-workers and caregivers. All of the people involved need to understand the older person and the means by which he or she can be helped to cope with physical and psychosocial needs. Among the professions frequently in demand now and surely to be in demand in the future, are physicians, lawyers, social workers, nurses, counselors, outreach personnel, recreation specialists, physical therapists, nutritionists, occupational therapists, speech therapists, architects, educators, and ministers and rabbis. These professionals have skills that can be enhanced through gerontologic and geriatric training. As we noted in Volume I, it is better to operate on the basis of knowledge than on the basis of stereotypes about the older population.

Chapter I: Manpower Opportunities, Resources, Realities

The earlier volumes of the 1966 series "Working with Older People" --prepared by the Gerontological Society under contract with the United States Public Health Service--were a timely contribution to the arsenal of training tools in the field of aging. The volumes filled a dual gap: they systematized gerontologic knowledge for the growing cadres of professional neophytes; they reinforced the skills and resources available to policy-makers, planners and service providers.

More than a decade ago, there were warnings of an impending manpower deficit of critical proportions. The Secretary of Department of Health, Education, and Welfare reported to the Congress in 1969:

> (There is) an urgent and increasing need for personnel to serve in the field of aging. The need for trained workers in 1980 would be at a level two or three times above that of 1968. [1]

The report indicated that at least a third of a million professional and technical workers were employed in programs serving older people.

The creation and expansion of service programs under Title XX of the Social Security Act and Titles III, VII, and IX of the Older Americans Act exacerbated the manpower crisis, especially the need for minority personnel. Positions for professionals, paraprofessionals and volunteers opened up at a dizzying pace. The network of area agencies on aging (AAAs), established by 1973 amendments to the Older Americans Act, constitute today nearly 500 offices, employing over 2,100 professional and 800 clerical personnel, not to mention over 7,000 part-time volunteers. In the underemployment economy of the 1970's, there was apparently no

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[1] Birren, James. Training in Gerontology: Principles and Pragmatism. Proceedings of the Eighth International Congress of Gerontology, Volume I, Abstracts of Symposia and Lectures. Washington, D.C.: International Association of Gerontology, 1969, p. 101.

difficulty in filling all new positions, but there are concerns as to whether the incumbents possess the skills and training to provide quality programs.

In the 1973 manpower report submitted by Elias Cohen to the U.S. Senate Special Committee on Aging, on behalf of the Gerontological Society, attention was drawn precisely to the fact that only 10%--and perhaps no more than 20%--of the technical workers serving older persons had any formal training in aging. The projections of need for 1980 were again two to three times above the 1969 level. Nursing homes would have only half the required registered nurses and less than half of the necessary licensed practical nurses. Also by 1980, there would be a need for 32,000 to 43,000 management and social services personnel in retirement housing, a 600% increment over the 1968 level. Twice the 1968 level of professional social services staff in senior centers would be required by 1980.

There are more than 700 nutrition projects for the elderly across the nation, encompassing several thousand nutrition sites. According to one projection, more than 82,000 persons may be serving the elderly now in these programs; most lack the most basic gerontologic training. There are no reliable projections of need concerning social-insurance specialists, health maintenance organization (HMO) administrators, medical, teaching, and legal personnel. It is obvious that if cancer, stroke and heart diseases are ultimately vanquished or their incidence lessened, there will also be a lengthening of life expectancy and a need for more services.

Institutions of higher learning are attending to these demands with degrees of uneven commitment. There is a very limited resource base from which to build training programs and careers. In a 1973 report, the Education Committee of the Gerontological Society stated that:

> ...research manpower in gerontology is inadequate, ... the cadre of trained teachers at all levels of higher education is inadequately small, and ... the number of trained service personnel to meet demonstrated needs of elderly citizens is inadequate. [2]

Few of the nation's 114 medical schools, 1,430 registered nursing programs and 1,300 licensed practical nursing programs offer systematic study in geriatrics, or even isolated courses in the subject. More than 1,000 institutions of higher learning do offer courses in gerontology but long-term career training, either as single disciplines or as a substantive formal specialization within defined academic or professional careers, is still in a precarious state of planning.

The bulk of the demands seems to lie--at this writing--in short-term training, related to specific jobs in ongoing programs. This is a concrete, problem-solving and issue-oriented form of training; it is not theoretically compartmentalized along the traditional boundaries of academic subjects. Short-term training is addressed to the overwhelming majority of practitioners who have neither the possibility nor the need for undertaking degree-oriented courses. Short-term training thus transcends the conventional adult education format because it represents closer integration of the academic disciplines into the day-to-day field and service operational problems. Moreover, it can also provide enrichment. It is precisely for this type of interfacing that the editorial

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[2] Cohen, Elias. Statement on Behalf of the Social Research, Planning and Practice Section of the Gerontological Society. In Training in Gerontology. Report of Hearings before the Special Committee on Aging, United States Congress, 93rd Congress, First Session, Part 2, June 21, 1973. Washington, D.C.: U.S. Government Printing Office, 1973, p. 128.

committee of this series on "Working with Older People" designed its content and format.

There is no consensus, however, as to what constitutes optimal or model professional preparation in the field of aging, regardless of whether the training is packaged in extensive career sequences or time-limited, non-degree-oriented programs. Curriculums are still evolving and training resources are continuously in experimentation. Many practitioners believe that skills and knowledge for working with older persons are better acquired on the job and that formal education in gerontology is not essential. Others take the opposite view: a proper theoretical overview should be the prerequisite for field experience. The latter, they contend, certainly provides exposure and sensitization to reality, but the understanding of the underlying processes and determinants of that reality can only result from a cognitive, academic base.

Efforts to develop didactic and training tools in the field of aging aim not only to systematize knowledge, but also to change stereotypes and misconceptions about aging. Louis Lowy, in one of the most popular training manuals of the early 1960's, sought to establish precisely a new attitude based upon scientific research, one that might eventually evolve into a sort of "ethos," intrinsic to the thinking of all gerontologic practitioners. Ten assumptions were then spelled out to this effect:

-- Aging is universal.

-- Aging is normal.

-- Aging is variable. (The way a person ages is unique, resulting from his or her ethnicity, minority status, and pattern of life experience.)

-- Death is normal and inevitable.

-- Aging and illness are not coincidental.

-- Older persons constitute three and even four generations (from age 65 to 115, a span of 50 years within a single age category).

-- Older people can learn. (The speed of learning may be slower but the learning may be more meaningful.)

-- Older people can change and adjust to new circumstances.

-- They wish to remain self-directing.

-- They are vital human beings who, even when suffering handicaps or physical limitations, are not necessarily inadequate.

Lowy felt that practitioners, dealing mostly with the sick and institutionalized may project their negative experiences to the well aged, thus failing to realize the inherent possibilities for growth and development that exist in older adults. Those observations are as valid in 1978 as they were 10 years ago, particularly in light of the recent drive for a national policy on the frail elderly. The Federal Council on the Aging in 1976 defined the latter as:

> ...those individuals within the overall population of older people who by reason of problems associated with health, economics, housing, and family/personal supports find it difficult to cope with the vicissitudes of life in a satisfactory manner. Some are functionally impaired and, as a consequence, are dependent physically on others for regular assistance

in the performance of essential activities associated with normal maintenance of life.[3]

Despite their high risk status, however, the frail elderly have the potential to remain in the community and continue leading reasonably independent and satisfying lives, provided they receive adequate service supports in their own places of residence. For example, let us take age 75 and over as a plausible indicator of frailty or high incidence of dependence. The number of older persons in this age category grows at a higher rate than that of the general population aged 65 and older. It is estimated that the 75-and-over group will represent 38% of the aged in 1980--or about 9.1 million persons. By the turn of the century, they proportionally will be 44%, or 13.5 million. Estimates of the proportion of the frailest and most dependent among the 75-and-over age group range from 9 to 20%, depending on the definition and assessment methods of functional impairment. There is no doubt, however, that frail older persons represent the fastest growing population among the elderly.

If policy directives insist that older people's freedom of choice in community living be maximized, a new set of service care systems and professional skills will have to be created. Workers serving the aged will need to be equipped with sophisticated intervention skills, some of which are yet to be shaped or refined. Assessment methods, for example, tend to put too much stress on functionality and inventories of salient health and sociopsychologic deficits. They are not equally capable of revealing the cathected flexibility of the aged individual--his or her motivational disposition--in coping with stress. It should be warned that health

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[3] Annual Report to the President. Washington, D. C.: Federal Council on the Aging, 1976, p. 25.

professionals may destroy--by appending a "sick" label to people--peoples' potential resources for handling their individual vulnerabilities independently.

As Neota Larson once pointed out, differentiating between the capable and "incapable" is not easy:

> One can seldom say, for example, that on this day or in this week, an adult who had previously been able to meet and resolve the problems of everyday living with reasonable prudence became incapable of doing so. Moreover, loss of capability may be uneven...an older person may be "childish" in his conversation but regular in meeting his financial obligations. [4]

The formulation of a coordinated service plan and implementation by case management--adapted to the personal needs of each older person--also constitute a new domain of professional intervention. The implicit objective is the integration of preventive, ameliorative and supportive health and social services. The viability of this objective rests on the assumption that there is an adequate continuum of community services. Reality, however, could prove to be very disappointing for the novice. To begin with, there is the striking inconsistency between prevailing policies and the needs of the frail elderly. Services provided under Medicare, for instance, are responsive to short-term acute and episodic illness, not to long-term disabilities. Besides, it ignores the need for certain home delivered services. Long-term care, in turn, is offered

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[4] Larson, Neota. Protective Services for Older Adults. Public Welfare, 22 (4), 1964, p. 248.

through Medicaid on a means-test basis, thus excluding all but the most impoverished aged from receiving this form of publicly-supported care.

In addition to policy gaps, there are scores of operational deficiencies: services are often not accessible, do not meet basic quality standards, are not adaptable to the clients' changing needs. These deficiencies undermine the information and referral effectiveness of the gerontologic practitioner. Other skills have to do with the changing value orientations and interests in the American society.

During the late 1960's and early 1970's, early retirements were considered a desirable option. But the liberalized Social Security provisions resulted in a sort of contradiction: with the introduction of an element of choice came policies of fostering early retirement, thus reducing competition for jobs by older workers. Another trend has emerged. It aims at abolishing mandatory retirement. Delaying use of Social Security benefits is one result welcomed by those who fear bankruptcy of the Social Security system. The movement against mandatory retirement retains the same principle of freedom of choice as early retirement. If confidence in the fiscal viability of the Social Security system is restored, more people may choose to retire before age 65.

Despite raising the retirement age to 70, retirement before age 65 is gaining in popular acceptance. Gerontologic practitioners may thus be confronted in the near future with increasing numbers of leisured, younger retirees whose primary value is no longer work. Practitioners will then have to come to terms with a new philosophy of leisure, centered around a sense of self-directedness and quality of life. These concerns are becoming more evident in all age groups. The practitioner will find himself or herself involved in matters transcending the gerontologic boundaries of his or her work. The profession is still in the making.

In the meantime, it is legitimate to ponder the marketability of a degree or concentration in gerontology. What is the employment potential of specialists in this field? Many expert observers are optimistic about the long-range prospects. They base their conclusions both on the demographic facts (presented elsewhere in this series) and the anticipation--by the expanding cohorts of aged persons and their relatives--of more and better services.

The immediate prospects, however, do not sound encouraging. Most jobs in the field of aging depend on public funds, but federal, state, and local governments prefer to make only short-term commitments. Uncertainty often overshadows the desire for continuity of programs. Workers may be constantly ridden with anxiety. Cynicism may surface when programs are terminated, not for lack of merit or success, but simply because of political expediency or budgetary priorities. Merit or success may have little bearing on such decisions.

Job openings in aging do not occur because of replacement of workers who retire or die. They are often created or improvised from scratch. The number of such jobs may not match the number of graduates from gerontologic education programs.

Employment opportunities also are contingent on the primary professional discipline in which the worker majored: nursing, public health, social work, urban planning, nutrition, guidance and counseling, public administration, law. At times, there is relatively more need for nurses than for nutritionists, or for more public administrators than for social workers, but this could be only transitory reflections of whatever program happens to become a popular cause for funding. Paraprofessional jobs are easier to find than professional ones. For example, there may be many

openings for paralegals, but an idealistic lawyer willing to devote his or her expertise to public service and the aged may find a totally unreceptive market.

The professional field of gerontology holds, in essence, many promises. But it will take time until these latent career opportunities are fully realized. Planners and practitioners in the meantime must attend to their client service needs without having always available a ready-made and tested service system. It is often up to them to define and design new services. It is also their ultimate challenge to propose new legislation and to advocate service reforms and entitlements. Needless to say, idealistic planners and practitioners may find this a highly creative and pioneering task, but it is also a very demanding one, where the signs of "combat fatigue" show at an early stage. They share, in all instances, the excitement and frustrations that go with building a new field of service.

These two volumes aim to assure that the building process will rest on reliable foundations.

Chapter II: Continuum of Human Services

Each practitioner may very well be able to see the merit of his or her own efforts but not be attuned to the diversity of: (1) needs that exist among the elderly, (2) services to meet these needs, and (3) other practitioners' perspectives. In this chapter, we present an overview of the needs of the elderly, followed by discussion of how needs change with increasing age--from the middle years through young-old and old-old years. An orientation will be provided to human services that must be mobilized to meet changing needs. Special emphasis will be placed on social services because of their critical functions in integrating services. We also examine the variety of human services practitioners.

Against this background, the relationship between the continuum of functional capacity in individuals and the continuum of human services in the community will be considered by focusing on three ways of structuring service:

1. Individually delivered (or home based);

2. Congregate-delivered, through senior center or other site away from home; and

3. Congregate-delivered through a common residence (e.g., senior housing or long-term care facility).

Lastly, some unresolved dilemmas related to the organization of services will be raised, such as whether services should be age-segregated (for the elderly alone) or age-heterogeneous.

AMOUNT OF SERVICE NEEDS

Given the remarkable heterogeneity of the elderly, there is no simple way to assess their service needs. It is obvious that their needs are large and largely unmet. The results of surveys designed to measure

how the elderly perceive their needs must be tempered by the distinction between objective and subjective assessment of personal need. For example, a 1976 study of Chicago elderly by Bild and Havighurst showed the black urban elderly, though relatively poor, had higher levels of life satisfaction than the wealthier white urban elderly. It is possible that the black respondents differed in their expectations and perceptions of their needs. Yet, their satisfaction may not mirror their ob ective status: they may not have the resources to enrich life, nor be free of crime or physical or mental deterioration. Their lives may indeed be precarious. On the other hand, the more affluent middle class elderly may be more likely to use services when their objective status does not warrant it. The term "worried well" has become a cliche to describe these more affluent elderly who seek out medical services because of their anxiety.

Still, by any reasonable definition of impairment, the vast majority of the elderly is not impaired to the extent of being unable to function in the community. Even if a rather loose definition is used, fewer than one of five persons 65 and over needs a high input of services. When functional health status is considered, 8% of the elderly are homebound (one of four of whom is bedridden), and another 6% are quickly moving into that condition (Shanas, Townsend, Wedderburn, Friis, Milhoj, and Stehouwer, 1968).

A systematic study of the functional capacity of community-living persons was undertaken by the U.S. General Accounting Office (GAO), agency of Congress. A random sample of 1,609 persons 65 and over who lived in Cleveland was assessed as to social, economic, mental, and physical

functioning, and activities of daily living. The survey revealed that 60% were relatively unimpaired; 17% were moderately impaired; and 23% were severely impaired. The distribution was comparable to that among elderly persons in a Durham, N.C. survey by the Duke Center for the Study of Aging and Human Development. (The Center developed the instruments used both in Durham and in Cleveland.) As expected, higher levels of impairment were associated with being older, being black, and with less income and education.

The GAO study also contained useful findings on the utilization of services:

1. Some people who could benefit from medical services had not received them, and many others who were not impaired in physical health were receiving medical services;

2. Most older people receiving social and recreational services (82%) were not assessed as being impaired socially;

3. Most older people (87%) had someone to turn to for help;

4. Older people living in neighborhoods served by few agencies received considerably fewer services than those living where many agencies provided services;

5. Low-income, inner portions of the city had high agency-service levels, whereas high-income neighborhoods had low agency-service levels, suggesting a lack of services for older people with high impairment in high-income neighborhoods;

6. Older people in public housing were much more likely to receive multiple services; and

7. Many older people who had income low enough to be eligible for programs were not using the programs.

Most significant for discussions to follow was the finding that 50% of the elderly received personal-care services from family or friends, and often from both. Because of this care from family and friends,these older people appeared to be suffering from little functional impairment. Older people with little or no impairment were receiving the type of interpersonal aid that enhanced that capacity to function. Thus, these old people reported adequate self-care, when in actuality it was not self-care but care by others. It appears, therefore, that informal supports are generally available and used but that formal services are often not available and, when they are available, are often not used.

Too often, only information and referral are available. The GAO surveyed 118 agencies providing services to old people. Of these, 77 (the largest number in the sample) were providing information and referral services; seven (the fewest) were providing continuous supervision; an intermediate number provided the rest: 61, social/recreational services; 51, escort; 43, outreach; 36, mental health; 30, relocation and placement; 22, medical; 16, multidimensional evaluation; 14, personal care; and 14, homemaker. Obviously almost all agencies were prepared to offer information and to refer clients, but only a few were providing the more costly and needed services for the old-old, in need of help, i.e., continuous supervision and personal care. Information about the quality and utilization rates for these protective-type services were to be compared after a year.

AGING AND SERVICE NEEDS

Simply cataloging current services, including rates of use, gives a distorted view of service needs. Statistics on the incidence of functional impairment provide too static a view. A more dynamic and realistic view can be achieved by considering incidence of impairment in the light of what happens in the latter half of the life cycle. It is important, for example, to consider both the common crises encountered by the older person and the support available to people experiencing these crises. As events or crises occur, social institutions become important in the provision of needed supports and opportunities. The interplay of crises and institutions is depicted graphically in Figure 1, reproduced from Tobin, Davidson, and Sack, Effective Social Service for Older Americans (1975).

With increasingly frequent early retirement, it is useful to think of two categories of older persons, the "young-old" and the "old-old." Neugarten (1974) defines the "young-old" as persons aged 55; they are relatively healthy, affluent, free of traditional family and work responsibilities, and increasingly well educated and politically active. The "old-old" in contrast, are generally over 75 and are more likely to need a range of supportive services.

The young-old cohort needs meaningful leisure time activities, including opportunities for community participation and public service. Most young-old persons would prefer, after retirement, not to work in the labor force. They need opportunities to be, for example, a participant at a senior center or a student in a class on current events or a volunteer, who uses time and skills on a personally meaningful project. Often, however, opportunities that seem appropriate or available to the elderly

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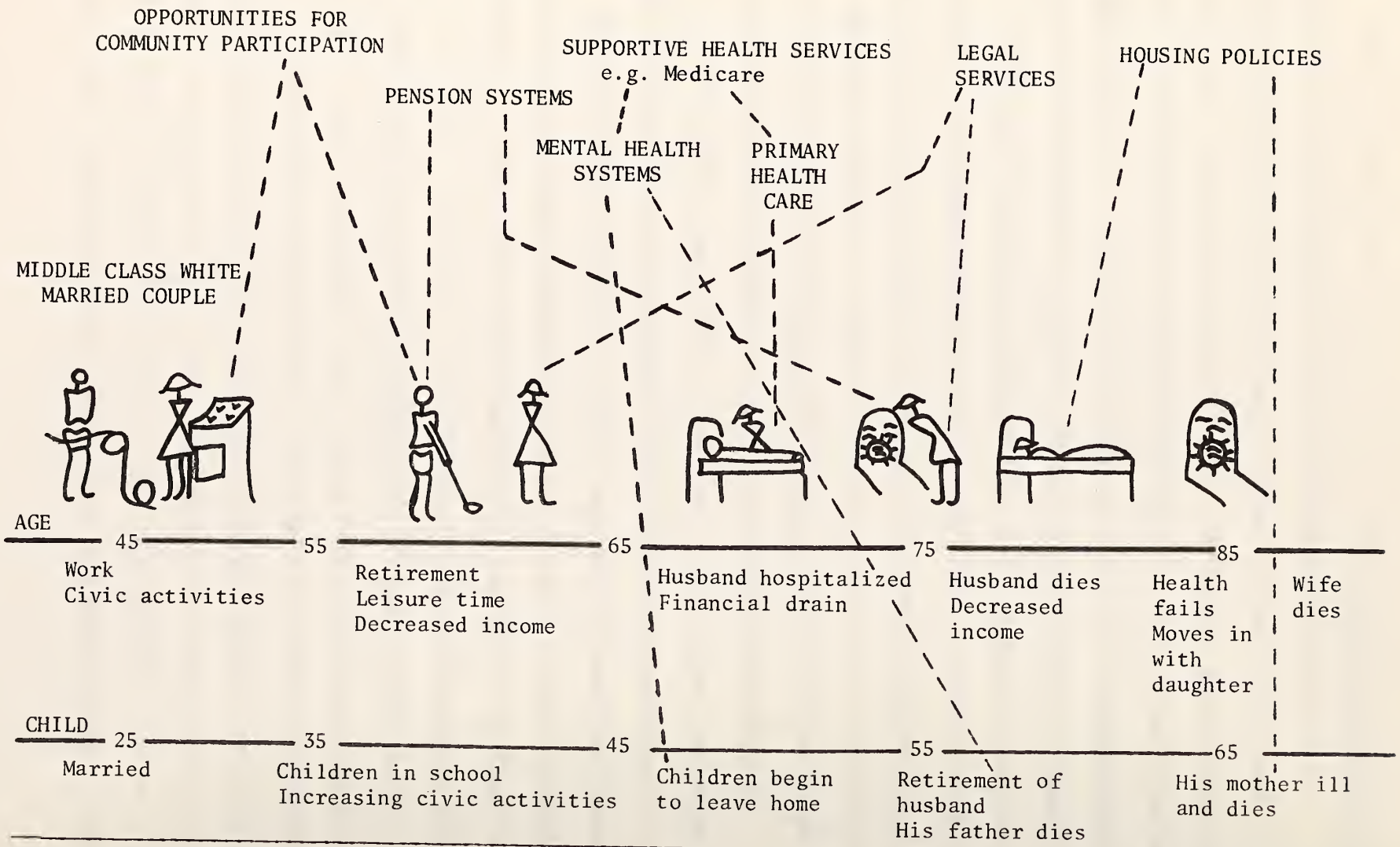

Reproduced with permission from Tobin, Sheldon S.; Davidson, Stephen M., and Sack, Ann. Effective Social Services for Older Americans. Ann Arbor: Institute of Gerontology, 1976.

may not be because older people may lack money, transportation or housing that promotes self-fulfillment.

The use of opportunities for self-fulfillment among the young-old often are diminished because of their need to care for old-old parents. The GAO found that when old-old parents, in their 80s or 90s, are deteriorating physically and mentally, the young-old provide considerable personal care for them. The young-old often provide these parent-caring services at a time when they though they could relax and enjoy their retirement years. Thus, the young-old at retirement may be involved indirectly--through parent-caring--in the income-maintenance system (private pensions and Social Security), community and civic activities, and in the health system.

The old-old, too, participate in a variety of service-delivery systems. As mentioned earlier, the current old-old cohort, usually above the age of 75, is generally less healthy and vigorous than the young-old, has less formal education, and has more acute financial needs. Their needs for meaningful ways of spending time and for special housing depend largely on their health status. Because of fragile or poor health, an expanded range of services for the old-old is extremely important. The majority of the old-old, though living independently, need both supportive social services and special adaptations of their physical environment to enable them to function as fully as possible. If the option exists, the impaired older person might move to a facility that promotes independent living.

The old-old individual increasingly contacts components of the health system. An accident or illness may necessitate a lengthy hospitalization. Death of a spouse may precipitate need for mental-health services. Expenses may deplete the old-old individual's savings, producing

dependence on public aid. This may be especially difficult to accept for an older person who has always made his or her own way.

Each system encountered by the old-old should not only be oriented toward preventing further decline in physical and social functioning but also should be designed to enhance feelings of self-worth and dignity. As with the supports available to the young-old, those provided the old-old are fragmented and fall short of meeting the needs of individuals.

From another perspective, the practitioners in any human service area must be aware of different cohort needs. The educator must consider not only programs for the vigorous 60-year-old person, but also for the 75-year-old person with a sound, inquisitive mind but with restricted mobility,or for the institutionalized 92-year-old person in a wheelchair whose mind is alert. The mental-health planner, similarly, must consider likely life-cycle scenarios. Widowhood may be followed by a mourning process that is needlessly protracted. It may be useful to establish a Widow Registry, as is the case in England, where widows can be identified and offered help. The 75-year-old woman who is acutely confused due to isolation while recuperating at home from a broken foot must not casually be labeled "senile" and sent to a state mental hospital. Nor must the 92-year-old man in his first week in a nursing home be assumed to be intractably incontinent without efforts to deal with the confusion and depression of relocation. The physician must not tell the 60-year-old blue-collar retiree that his chest pains simply reflect his being out of work (not working may be lethal to physicians but health actually improves from pre- to post-retirement for blue-collar workers). For the 76-year-old woman with an acute cardiac episode who will be chronically

impaired for the rest of her life, an orientation to acute cure rather than care will not suffice; nor will simply prescribing a salt-free diet to the 91-year-old man in a home for the aged whose heavily salted fish has been his one joy in an otherwise bleak old age. Indeed, within every area of human services, attention must be on the diversity of target groups among the heterogeneous population of the aging.

AREAS OF HUMAN SERVICES

Many human services were originally conceived to be needed only by the very poor for rehabilitation, enabling them to rejoin the mainstream of society. Because the defect was perceived to be in the individual and not in society, social services stigmatized users as well as providers. More recently, however, human services have come to be seen by many as a right to be guaranteed to all. This does not mean that all people should receive the same amount or type of service but rather the services that, in the long run, allow everyone to reach a basic level of physical and social well-being. Over the short run, certain groups and localities will need more services than other groups and localities.

How have human services been categorized? According to the Allied Services bill of 1974 (92nd Congress, 2nd session, S. 3643, H. 15856):

> The term "human services" means services provided to individuals or their families in need thereof to help them achieve, maintain, or support the highest level of personal independence and economic self-sufficiency, including health, education, manpower, social, vocational rehabilitation, aging, food and nutrition, and housing services; and the term "human services program" means a project or program under which one or more human services are provided.

This concept does not cover income maintenance. It is considered "hard" service as compared to "soft" services where the value is harder to measure. Nor does this concept cover the family's own support for its members and services provided by commercial organizations. In sum, human services are those non-income programs that help families and individuals by providing (money-equivalent) benefits through public programs.

Regarding human services for the elderly, the Older Americans Act, as amended in 1973 (PL 93-29), included all but health services. Indeed, at the federal and state levels the trend is to separate income-maintenance and human-services programs, and then to divide human services into physical-health programs and other programs, basically the traditional social-service programs plus some additional human-service programs. Title XX of the Social Security Act authorizes grants to states for human services. Enacted in December, 1974, P.L. 93-647 funds traditional social services and such other services as transportation and education.

But what precisely are social services? To resolve the vagueness of the term, Kahn (1973) has suggested that social-service programs are "programs that protect or restore family life, help individuals cope with external or internalized problems, enhance development and facilitate access through information, guidance, advocacy and concrete help of several kinds."

In this framework, which is perhaps most useful for setting up social-service boundaries, three functions are primary. The first function of social services, as Kahn defined them, is "socialization and development." This includes activities that once were provided by the family or friends

but now are given by day-care programs, meals-on-wheels, youth and senior centers, family-planning centers. The second function is that of "therapy, help, and rehabilitation." The emphasis is on personal help with situational, interpersonal, or psychologic problems. Included here are such services as child welfare and family casework, group thereapy, medical social work, protective services for the elderly, and institutional care for delinquents. The third function is that of "access, information, advice, and referral." With its emphasis on effective service delivery, this function is important to the social-service goal of redistribution of opportunity and assets. Redistribution can begin to be achieved if universal rights, benefits, and entitlements are assured, along with actual delivery and use of social services. Social workers or others may attempt to inform potential users of the services available. They also establish and strengthen linkages between the users and the programs, as well as between and among programs, assuring that they are both accessible and used.

An Under Secretary of the Department of Health, Education, and Welfare, Frank Carlucci, in 1974 emphasized case management as a special role of social services within the larger human-services spectrum. He said that case management means, first, making "a comprehensive assessment of a person's multiple needs for services at a single entry point, then (taking) responsibility for seeing to it that appropriate services are provided." This service-integration function, critical to the Allied Services Act, represents a major thrust of the Older Americans Act as well. Certainly, the proliferation of differentiated services warrants some form of packaging by skilled professionals on behalf of the elderly.

The growth and development of social services has been unsystematic. Services that indeed could form a system have come into being separately as each extra-familial need was identified. This history explains much of the random and disjointed characteristics of social services today. Nonetheless, they share basic premises, among them:

1. Objective and subjective functioning are both essential aspects of human benefit (or outcome). "Objective" refers to readily-visible physical and social functioning. "Subjective" refers to feelings or states, including morale. Optimally, the outcome of services is improvement in both. That is not always possible. The complex relationship between subjective and objective functioning is illustrated as noted earlier in this chapter by poor elderly persons who live in what may seem to be the most wretched circumstances but report satisfaction with their lives. Happy to survive, they feel that whatever they have is better than what they hoped for. The affluent elderly person, on the hand, may feel loss of self-esteem and may be able to list absent services that could enhance his life.

2. Improvements to be achieved will vary by initial client status. For those who are now adapting adequately, improvement may refer to enhancement or self-actualization of the full human potential. For others with moderate limitations, improvement may refer to rehabilitation or to maintenance or stabilization of physical and social functioning. And for others with extreme debilitation, improvement may refer to restoration or rehabilitation of lost functioning or to adjustment to living with their impairments.

3. Client-perceived need and professional judgment of need may differ. "Need," however, refers both to what the person says he needs and

to skilled professional judgment of what he needs. Both aspects must be considered; differing assessments should not be seen as competing with each other.

4. Enhanced functioning should facilitate both a person's sense of individuality and of connectedness. Too often, we emphasize individuality (e.g., "encourage dignity," "avoid making the client dependent") but pay insufficient attention to independence, the goal being to facilitate and enhance effective relationships with family, friends, and others in one's own community. Encouraging independence is a difficult task because dependence on another person--or even on a service system or a machine--often is essential to continued functioning and the maintenance of life and hope-sustaining relationships with other people. Sadly, attempts to promote independence or to avoid institutionalization often weaken the client's meaningful links with his family, friends, and community and increase his psychologic and social isolation.

For those in administration, there are goals associated with developing effective systems of service delivery. Since a system, by definition, comprises elements subject to a common plan or serving a common purpose, we must consider effective relationships of elements among themselves and with other systems. Let's consider service-delivery goals and organizational goals.

Service-delivery goals concern the smooth integration of services to individuals. The services must be accessible to the target population, receptive to the idiosyncratic needs of each client entering the system, and able to provide sufficient options for each client and to provide multiple services, simultaneously and in appropriate sequence.

Organizational goals serve service-delivery goals. The system of services must be coordinated in order to attain service goals, and planned so that resources may be allocated and distributed rationally. Major attention should be given to meeting client needs. In so doing, mechanisms must be developed so that consumer and community input are used creatively.

These service-delivery and organizational goals are essential to effective client service as well as for unifying larger systems of service delivery.

THE VARIETY AMONG PRACTITIONERS

The goals just listed must guide the practitioners and the administrators. Many human-service practitioners combine elements of both direct and indirect practice in their work. The registered nurse who works in a community health program may assess and treat elderly patients in their own homes, supervise licensed practical nurses and plan services for new target groups. The community organizer may develop task-oriented groups among residents of an urban high rise, linking residents to service given by a host of agencies. The medical director in a long-term facility will not only treat residents (or patients) but administer a medical program and plan social health programs with other professionals in the facility. Most practitioners probably spend almost all their work time in either direct or indirect practice.

It is also likely that their tasks entail a diversity of treatment modalities. The recreational worker in a neighborhood center may be working with groups of elderly people as well as counseling individuals. In an institutional setting, the activity therapist may be chairing team

meetings, developing treatment plans for individual residents, and applying behavioral therapies to the mentally impaired elderly. The health planner in a Health Systems Agency may be developing ways to assess the need for home-delivered health services while generating legislative proposals to increase the flow of these services. At the Area Agency on Aging, the program specialist may be planning how to deploy an on-demand transportation program and analyzing legislation to determine whether additional funds are available to expand or even maintain the service. The specialist's job will encompass more than one type of human service and involve the direct and indirect levels of practice.

CONTINUA: FUNCTIONAL CAPACITY AND SERVICES

For older people anywhere in the continuum of need or impairment, services can be organized around the home, a place of congregate activity, or a congregate residence. In the first part of this trichotomy, the individual in his own home is helped to live there by delivering services to this setting or by transporting the person to a place of service and back to the home. Congregate-delivered services are those provided to elderly persons as a group at a multipurpose senior center or other site of group activity. In the third approach, the individual or group of elderly persons live at the service site, such as a nursing home or a congregate housing project offering recreational, nutritional, and clinical services.

ALTERNATIVE WAYS OF STRUCTURING THE DELIVERY OF SERVICES

A CONTINUUM OF SERVICE:	HOME-DELIVERED	CONGREGATE-DELIVERED	
	(Client lives at home)	Congregate-Organized (Client lives at home)	Congregate Residence (Client lives at service site)
From services for the comparatively well elderly	Outreach Information and Referral Telephone Reassurance Friendly Visiting Work at Home Senior Wheels to: shopping, doctor, dentist, and social functions	Adult Education Recreational Senior Center Nutrition Sites (Wheels to Meals) Sheltered Workshops	Senior Housing (includes retirement hotels) Senior Housing with Recreation and Social Services
Through services that provide alternatives for preventing premature institutionalization	Escort Service Homemaker Service (housekeeping, handyman, etc.) Meals on Wheels Home Health Care (visiting nurse, rehabilitation, speech therapy, dentist, and doctor)	Multipurpose Senior Center (all of the above, plus outreach, health, and social follow-up)	Sheltered Care Halfway Houses
To services for those whose needs may demand institutional care or its equivalent	Foster Home Care (complete social and health care for bedridden person in a home)	Outpatient Day or Hospital Care	Mental Hospital Institutional Care (Nursing Homes and Homes for the Aged) intermediate nursing care; skilled nursing care; short-term crisis care; and vacation plan Terminal Care

Reproduced with permission from Sheldon S. Tobin and Morton A. Lieberman, Last Home for the Aged. San Francisco, California: Jossey-Bass, Inc., 1976.

The entries on the accompanying chart refer primarily to structuring social services. The trichotomy, however, is useful in planning for all human services. For example, in deciding on the location of adult education classes, the planner in education must consider the utility of a community college or a senior housing project. The advantage of the college location is that the service can be offered to a wider audience--the less impaired, primarily the young-old--than would be the case at the housing project. Yet, residents of the project, who are more likely to be physically disabled, may benefit as much if not more from the classes.

Similarly, the transportation specialist must consider the distribution, living arrangements, and disabilities of the elderly population needing service. These characteristics will help determine use of fixed-route minibuses or on-demand limousines, which are suited for the dispersed elderly. Reduced fares become important when the practitioner attempts to generate self-help among the elderly. That is, those able to give help, generally the young-old, are likely to be dispersed in the community and need inexpensive transportation. As a population ages, the strategies for giving service may change from home-based to congregate-residence-based.

SOME DILEMMAS IN SERVICE DELIVERY

- Should the elderly be served separately from other age groups?
- Should priority be given to certain elderly persons at the expense of others?
- What weight should be given to efficiency of service delivery versus patient (client) preference?

These are among issues the human-service practitioner faces in planning to meet needs within resource limits. The best resolution of what we may call "dilemmas" is not always clear.

We will discuss a few dilemmas in terms of client-focused, structural and strategic considerations.

Client-focused Considerations

The issues posed above are in this category. In answering the first, (should the elderly be served separately from other age groups), one may argue for separation on the basis that the elderly have special problems requiring the bringing together of specialists, that the elderly tend to lose out when mixed with other age groups, and that they are strengthened by peer interaction. Arguing against age segregation are (1) lower costs of delivering services when persons of various ages can share them, and (2) avoidance of age-segregation. A possible solution is to offer age-segregated services, with linkages to age-free services.

In considering how to allocate resources, one might argue that something should be offered to all the elderly, the majority of whom are not impaired. On the other hand, the impaired elderly have urgent needs. A possible solution is to serve all the elderly to some degree, while reserving resources disproportionately for the impaired.

In deciding on service arrangements, one has to balance the virtues of home-delivered approaches (in serving clients in familiar, nonthreatening environments and obviating stressful relocation) against those of congregate approaches (the positive effects of peer socialization, promotion of a positive aging image, and lower costs). A mix of approaches often is most reasonable.

Structural Considerations

What degree of comprehensiveness can a system achieve? Comprehensive services can be advocated because they address the total range of

need, whereas fewer services provide intensive use of limited resources, are easier to implement, and promote development of expertise in specific problems. A compromise model would be a comprehensive system (1) capable of responding to a full range of service needs, (2) built around a case-management approach, (3) with agencies maintaining their own limited and expert focus.

A second structural dilemma relates to centralization versus decentralization of services and locus of authority. The compromise model is decentralized service delivery with centralized planning and resource allocation.

The third dilemma relates to coordination versus autonomy: how can the functional relationship be best articulated to maximize the range of client services? Arguing for coordinated services are the strengthening of agencies' capacities to deliver service effectively, and the promotion of specialization and refinement. On the other hand, coordination among agencies may be difficult to arrange. Autonomy allows for organizational structures that are simpler and easier to control. A middle course may be to link autonomous units closely enough to assure that clients move smoothly through the system.

Strategic Considerations

A first dilemma is public versus private auspice for planning and for delivery of services. The many pros and cons lead to suggesting a system where planning is congruent with local political realities and where service delivery draws upon the specialized abilities of disparate providers to fill service and organizational goals.

A second dilemma relates to provision versus purchase of service. Most sensible may be a combination of purchase and provision arrangements that;(1) promotes effectiveness through competition while allowing for semi-autonomous functioning; (2) assures the client of service while enhancing personal choice; and (3) provides for the minority elderly's special needs.

The last dilemma is that of professional or non-professional staff. Arguing for professionals is the higher skill level and the capacity to function independently; arguing for non-professionals (and for volunteers) is the promotion of effective linkages to community and natural helping systems, and the savings in cost--although training and supervision are not without costs. It may be preferable to have a mix of staff that includes a sufficient number of professionals to accomplish agency goals as well as volunteers who provide for cost-saving services and promote important community linkages.

These are only a few of the many dilemmas that must be kept in mind as practitioners and teachers read this volume.

Chapter III: Target Groups for Human Services

Section 1. The Unimpaired Elderly

INTRODUCTION

This chapter attempts to relate much of the general information provided so far in Volumes I and II to specific target groups. We have labeled them the unimpaired, minimally-impaired, moderately-impaired, and severely-impaired elderly. Chosen for brevity, these labels really represent the elderly in various functional categories or distances from independence. The labels might have been as useful, but longer, if they were "well or independent elderly," "comparatively well or independent elderly," "the elderly needing services to prevent premature institutionalization," and "the elderly needing institutional care or equivalent."

We have organized information for practitioners under these headings in order to picture the application of services to the needs of these kinds of elderly persons. Each category discusses who the target group is, the financial and personal resources of its members, their general needs for services, and assessment of individual needs.

We hope these mosaics will help you visualize the interplay of environmental, health, cultural, family and neighbor supports, and supportive services with the issues of how and where to care for these groups of elderly. This approach may be of particular value to planners.

For example, the provision of health-maintenance activities is important in keeping the elderly well or helping slow the functional decline of those with infirmities. To the extent that health maintenance is successful, elderly persons will be able to maintain themselves for a longer period of time in the community rather than in an institutional bed. With a more active elderly population resulting from good health maintenance efforts, the emphasis on--and the demand for--community

services to meet health and psychosocial problems surely will grow and confront practitioners and planners with complex challenges.

Planners face a different set of options when policy on cash assistance changes. If the decision is against more cash assistance, the need for direct provision of health, nutritional, and housing services will be all the greater, especially for the impaired elderly. A look at the data may suggest priorities on whom to help first. For example, programs to assist families in the care of older persons may deserve a larger priority, because the impaired elderly who live with relatives tend to have lower income than those who live with nonrelatives. The fact that the older elderly and the nonwhite elderly with impairments tend to be in low-income families has planning implications. The more support given families, the more likely it will be for the elderly to be maintained at home in the face of worsening infirmities. Based on a community decision to encourage home care, the planner may be called on to specify the type and mix of services that will be most effective.

The picture we try to present through these target groups focuses on the interaction of natural or informal support systems with the work of practitioners in home-care, housing, human-services and health-care activities. The decision for or against institutionalization may go one way or another depending on the ability of family members, friends, and neighbors to help the impaired elderly person at home. Older people perceive this informal network of kin (particularly children), friends, and neighbors as the most appropriate source of social support in most situations of need. Only when such assistance is unavailable or exhausted do the elderly turn to formal organizations for services work. Whether the support system is formal or informal or a mix, the underlying

goal should be to strengthen the older person's sense of mastery over self and environment.

As persons get older, they tend to be increasingly neighborhood bound. Interaction with persons outside the neighborhood diminishes. Neighbors and friends (the distinction blurs) shop for each other, help out in emergencies, and do household chores. Neighbors accompany older people to the doctor, bank, Social Security office, and other places. The most frequent assistance is help in time of illness or emergency. The very proximity of neighbors makes them particularly important. It is not uncommon for a neighbor to assume enduring responsibilities or to take part in crucial decision-making if no spouse, child or other relatives is available. Visiting, sitting, talking, and eating with neighbors can be said to be among the many social support tasks essential to sound mental health.

The meaning of all this to practitioners is clear: they must be sensitive to the interactions of the elderly and their supporters. In planning with the older person for current or future needs, the existing support system should be preserved and used. One of the most traumatic effects of institutionalization is the removal of the elderly person from the support network. And vice versa. As a neighborhood changes or as neighbors move away, practitioners and the older person may find that the informal supports have vanished and substitutes are needed.

As the older person becomes frailer, the informal system carries the brunt of providing necessary assistance but the formal system increasingly is called on to meet such needs as home health services, family counseling, and transportation. When practitioners step in, intervention must be based on thorough knowledge of the client's environment, health,

financial, and psychosocial circumstances. The individual's problems must be surveyed in their entirety so that the most effective means is chosen of preserving or improving the individual's ability to function as independently as possible.

Two points need to be emphasized as we begin to look at the interaction of needs and services:

1. The continuum of needs will be presented in minimal-to-maximal sequence. This ordering does not imply that every elderly person experiences every level of impairment.
2. The gradual shift from minimal to maximal impairment tends to be associated with increasing age, according to data from a large population. However, in evaluating individual cases, one cannot assume a level of impairment exists simply because of the person's age.

THE UNIMPAIRED ELDERLY

Who They Are

The unimpaired, or independent, elderly are persons capable of meeting all their basic needs. They have no serious functional limitations. Such persons are most often found among the youngest "aging." Still at work or recently retired, they are self-directing and are capable of fulfilling their own basic needs. They are able to work full- or part-time, to utilize community resources, to live and travel alone. They get around without difficulty, and take care of their own customary personal needs and social interests. They maintain their own living quarters and manage their own shopping, cooking, and cleaning house. No physical restrictions appreciably limit their daily activities or their interpersonal and social relationships. Mild chronic health handicaps or minor disabilities

--such as controlled or treated hypertension or osteoarthritis which pose no continual adaptive stress--are not considered limiting.

They are adaptable enough to accommodate to the demands of daily life, to make decisions and plans, to pursue solitary and interpersonal interests, and to utilize the support and interest of others in fulfilling their tasks. They are capable of weathering minor problems or mild depression alone or with no more than the usual assistance and concern of others.

Continuity of household composition and of way of life is stable; these persons adapt to slow changes, but have not suffered sudden changes or hardships. Events requiring adjustments in their way of life are encompassable. Their major problems are likely to be adjustment to relinquishing work life and finding self-directed satisfying and productive pursuits.

Financial and Personal Resources

Standards of living, financial resources, living arrangements and social relationships and pursuits are adequate, in line with accustomed standards, and regularly maintained. These are not specially deprived or disadvantaged persons. They manage with reasonable comfort, security and pleasure.

Generally speaking, they have higher incomes than those older persons with some physical limitations, although their incomes tend to decline with age. According to 1974 data, about 90% of persons aged 45-64 are in family units with income above $10,000 but this proportion slips to 57% for persons aged 65 and older. Nonwhites generally are in lower-income families than are whites. While 59% of whites reporting no physical limitations were in family units with incomes above $5,000, the comparable nonwhite proportion

was 38% in 1974. The unimpaired elderly who live with relatives tend to have lower reported incomes and are older than those living alone or with spouses.

General Needs for Services

The programs used by independently-functioning older people are characteristically those they choose themselves for continuing interests, enrichment of life, and prevention of disabilities. They may take advantage of community programs especially designed for the aging, such as nutrition programs, continuing education, and legal aid services. Individuals in this category serve as volunteers, teachers or aides in various settings, and they assist in providing these and other community services to others. They may also participate in community-wide or senior citizens' interest groups, if these organizations exist in their communities.

Their health service needs are best understood against the background presented in the biomedical chapter of Volume I, a basic point of which was that the elderly person has less physiological reserve than the younger one. The practical significance lies in the need for service providers to detect diseases early, before these stress the reserves and become critical.

An allied point is that elderly people tend to have multiple diseases or disabilities the older they become. Any single illness may not be incapacitating in itself but may, appearing in context of multiple problems, undermine the individual's independence. The removal of small deficits may produce a dramatic improvement in well-being and restoration of independence, even though the individual still has major deficits or illness. An awareness of these facts underscores the need for the comprehensive

diagnosis of older peoples problems in order to maximize the older individual's ability to remain independent.

Health services for the independent elderly center primarily on preventive and health maintenance, broadly discussed in Volume I. The present discussion will highlight; 1) how environmental factors affect health; and 2) physical and mental health.

We often overlook home accidents as an environmental factor which may affect the health of an older person. The prevention of accidents at home is obviously important. Many precautions are beneficial for persons of any age, such as installing grab bars in the bathroom and providing adequate lighting, extending hand rails on stairs to the landing (rather than stopping short), eliminating scatter rugs or taking them down, installing fire alarms, and putting non-slip surfaces in critical areas. An accident may be the beginning of a series of problems. Consequently, the prevention of such accidents is of vital importance for the older person.

Some illnesses may be prevented by immunization against influenza, tetanus, and certain other diseases. The application of many, if not most, screening procedures of physical examinations or laboratory determinations probably would be more helpful as a preventive measure for the older person rather than the younger person. This is true not only because older people have limited physiological reserve, but also because diseases in the elderly tend to appear with signs and symptoms different from those evidenced by younger people, and thus are easily ignored or misinterpreted.

Preventive medicine for the elderly also requires attention to those physical health needs to which physicians often give lesser priority. For example, a catastrophic change in a patient's capacity for independent

living may be averted just as much by paying attention to problems of the legs and feet by paying attention to problems of the heart and brain. Physicians are also becoming increasingly aware that the treatment of hypertension and the cessation of cigarette smoking may well be as important to good health in the elderly as in the younger person.

The most common mental health problem of the elderly is depression, largely due to losses--of income, status, spouse and friends, and physical abilities. Many unimpaired elderly would benefit from making preparations --through counseling, education, and peer interaction--for the eventuality of these losses and their effect on psychological well-being. Such support mechanisms as retiree groups, activities that help integrate the person into new roles, and widows' groups can be beneficial in staving off depression or in minimizing its consequences. Giving attention to social and recreational needs may prevent a stark sense of isolation that can accompany old age.

Human service workers, physicians, and others working with the elderly can be effective in maintaining the mental health of older people if the service providers recognize depression and its probable causes in older people. Some symptoms of depression are the individual's feelings of sadness, hopelessness, helplessness, and worthlessness. In general, the longer an individual has these feelings, the less likely the depression is to improve. Other signs of depression are weight and appetite loss, bowel problems due to poor eating and awakening early in the morning without meaning to do so.

The major type of depression among the unimpaired elderly tends to be of relatively recent origin and to be related to an event, such as the death of a spouse. These are reactive depressions. It is rare that the

loss of a job causes depression. Those at high risk of job-related depression are likely to be persons who retired out of failure to achieve a goal or who retired without enough money. Generally, blue-collar workers are comfortable with the idea of retiring. Businessmen or professionals may not be traumatized by retirement, either, but for different reasons ; they often do not fully retire, preferring part-time activity.

A simple reactive depression may lift in three months. Chronic depression, however, endures. A series of hard knocks or persistent defeat alters the individual's personality. For example, chronic depression might occur in the woman whose husband dies, whose son goes bankrupt, whose daughter has cancer, whose leg has to be amputated and whose residence must be changed. The person who is chronically poor, who is only marginally solvent because of inflation, or who finds health steadily eroding may become chronically depressed. A particular problem group appears to be aged white men which has a relatively high suicide rate. Facing a serious disease or other calamity may also lead older people to heavy drinking.

Reactive and chronic depressions can result in serious physical problems. For example, the elderly person who stops eating may develop a serious vitamin or other nutritional deficiency, or may fail to take medicine necessary to maintain health. Because apathy can lead to poor self care and an eventual crisis, a program of preventive "watching" is worthwhile. Relatives and neighbors in the support system can be asked to keep an eye on the depressed individual. Professionals and others (such as deliverers of meals on wheels) also can play a role in monitoring the depressed person. In particular, depressed persons should be watched for excessive and inappropriate use of drugs and alcohol. Drug abuse and alcoholism can be problems whether they develop after age 50 or

before. Drug use and alcoholism may underlie or complicate issues for medical, nursing and human services practitioners.

Drug abuse or misuse, while dangerous at any age, is particularly dangerous in the elderly because the resulting physical incapacitation may be accepted as an untreatable consequence of "aging." It also may produce temporary loss of memory or disorientation. When these signs are mistaken for "senility," the individual may be left untreated. The older person often can be restored to health quickly through withdrawal of a drug that produces memory loss or disorientation.

The primary type of drug abuse or misuse among the elderly is not addiction to barbiturates or the morphine derivatives. Rather, it is the taking of multiple drugs--both prescribed and over-the-counter drugs. The chances of adverse drug-drug interactions rise as more and more drugs are taken. The stage for such interaction is set when: (a) the physician does not take a thorough drug history, (b) the patient does not list all the drugs he or she takes, (c) one physician prescribes without knowing what another physician has prescribed for the patient, or (d) a physician does not prescribe properly. Borrowing and lending of drugs--inappropriate in type or dosage for the borrower--and the "inheritance" of drugs (as when a decedent's pills are bestowed on neighbors) add to the causes of drug abuse and misuse.

The sudden appearance of certain mental symptoms--not only depression but confusion and disorientation--may be indicative of physical illness. After treatment of a fever-producing infection, for instance, the pseudo-senility will disappear. Likewise, the sudden appearance of paranoid behaviors may not be evidence of "senility" but rather of a

hearing loss. With proper diagnosis and treatment, including perhaps a hearing aid, the paranoia may clear up. A key principle for human services workers is to avoid accepting mental symptoms as unchangeable without searching for remediable physical and socioenvironmental causes.

Assessment of Individual Needs

The unimpaired elderly can be looked on as individuals who are likely to experience both declining health and income as they age. These typical declines have implications for planners and care-givers. Basically, this group of elderly persons needs services to maintain physical and mental health. They may need counseling and other assistance to prepare for contingencies.

The key to counseling or case management is a thorough assessment of individual needs. In a well-integrated network of supportive services, medical, nursing, and psychsocial data are gathered from primary-care physicians and through a visit by a nurse and/or a social service provider with the individual, where these are indicated.

Where there has been no recent physician contacts, a combined medical and nursing evaluation can be done easily by a geriatric (or internal medicine) nurse-practitioner, supervised by a sponsoring clinic or private physician group. This professional field worker has expertise not only in medicine and nursing but also in aspects of social work and understands the importance of functional disability and psychosocial evaluation as these relate to chronic illness.

As part of the psychosocial assessment, the informal support system of each individual must be identified. The roles played by members of the support system--immediate family, other relatives and

friends--should be appraised. Their involvement may be necessary later in maintaining the individual in the community.

Requests for needs assessment of the well elderly will, to a large degree, originate not from health-related service providers but from family members and human service providers. Community-based evaluators, mentioned above, should make complete assessments whenever possible, so that the process itself identifies where help is needed in order to prevent dependency and to maintain independent functioning.

The outcome of the evaluation, for the unimpaired elderly person, is most often a recommendation for preventive or health-maintenance care. Among volunteer activities the well older person may undertake is aid to the impaired or dependent elderly. The well older person who might become socially isolated can be referred into activities involving other people. A well older person may also benefit from services aimed at improving management of personal finances, elevating general nutrition, or preparing to adapt to changing roles after retirement.

Section 2. The Minimally-Impaired Elderly

THE MINIMALLY-IMPAIRED ELDERLY

Who They Are

The individuals in this group have some disability. They require some supportive services to maintain an independent life in the community but, by and large, can care for themselves. In the planning of services for them, income and living arrangements are key considerations in determining what is most appropriate.

These mildly-handicapped persons, generally retirees in the late 60's and early 70's, are able to live alone. They usually have a mild but chronic impairment in one basic area of functioning but can maintain themselves comfortably or satisfactorily in their own home with some family help, community service or planned program. Such help also acts to preserve their capacity to act independently. Persons in this group typically have slowly advancing disability from such diseases as osteoarthritis, heart and circulatory disorders, and metabolic imbalances. They also may have such other difficulties as visual defects which in turn affect their mobility and strength or capacity to manage their households without help. Occasional forgetfulness or moments of mild disorganization, not uncommon, may worry or embarrass them. Because of their disabilities, family, social and interpersonal activities may become somewhat restricted.

Income

In this group, individuals tend to have lower incomes than persons without impairment. Nonwhites tend to have lower incomes than whites, and persons living with relatives tend to have lower incomes than persons living alone or with spouse. To a greater degree than the unimpaired elderly, the minimally-impaired elderly especially the nonwhites, tend to live in families with incomes below $5,000.

The extent to which income is adequate for the minimally-impaired elderly is a matter of conjecture. It is estimated that probably more than 15% of these individuals live in families with incomes below the poverty line. Their impairments suggest they have a greater need for assistance than do the unimpaired. In short, they need more income than unimpaired persons but have less to maintain a satisfactory standard of living. Their housing, adequate in comfort or convenience, tends to be in older buildings in transitional neighborhoods. When their neighborhoods deteriorate they often find themselves in high crime areas. Fearing to venture out of their homes, they may become anxious and isolated.

Because of limited physical needs and the accompanying emotional stress, these individuals may require money for services they once performed for themselves, including such activities as housework and transportation to shopping places and recreational activities. For those older persons whose incomes are reduced, such expenditures may affect their ability to maintain even modest standards of living or housing. Reduced income and added expenses may also restrict access to ordinary services and programs, social and familial roles and relationships, and capacity and resources to cope with relatively minor problems of daily living.

Persons on reduced income may turn more and more to community agencies when their family members and friends move out of their neighborhood. They, therefore, become more dependent on community agency programs and resources for a sense of affiliation, personal involvement, and recognition as well as for services in time of stress. Thus, the range

of programs available to them may make a critical difference in their quality of life, including mental health.

Prospective or actual changes in living circumstances, the loss of conveniences, or even marginal decrease in ability to manage in the same surroundings threaten the tranquility of such persons. Their daily lives are likely to become somewhat more circumscribed, routinized or uneventful than they once were, but they may still remain active at a level satisfactory to them.

Physical and Mental Health

Their illnesses may be acute and occasional but predictably recurring, or of a continuous chronic nature, temporarily intensified. Depending on their physical state their service needs change from time to time. Service programs need flexibility in order to adjust to fluctuations in clients' needs. Even if there is some physical illness or activity restriction, many individuals require little personal care as long as they can obtain medical, nursing, or social-work supervision. They may continue to be self-managing in unimpaired areas of functioning. They can identify and seek out the help they need, travel to and use community-based services, and maintain family ties.

It is important to prevent any illness or disability that further compromises the person's ability to lead a reasonably independent life. Thus, in addition to preventive medicine, programs, the health care provider must be certain to diagnose all the patient's medical problems. It is often forgotten that the only way to find all curable conditions is through systematic collection of data. This can only be accomplished by thorough history-taking, physical examination, and laboratory testing. As for conditions

not considered "curable," they may well be responsive to therapies that can produce significant improvement in a patient's way of life.

The relationship of caregivers to the minimally-impaired person needs to be carefully considered. Their encounters should reinforce the individual's will and capability to remain independent and to maintain self respect. A relationship that fosters dependency is counterproductive. Yet, this often develops when the caregiver takes the superior posture of "I'm the helper, and you are the impoverished 'helpee' who must take orders." A productive caregiving attitude is one of consultation or facilitation by a person who is an intermediary for service the individual is entitled to have.

Respect for the patient should mean that management is tailored to personal circumstances. It is foolish to ask an older person to adhere rigidly to a low-sodium diet if the costs are prohibitive or if the diet is unpalatable. Patient management may be enhanced in many cases by a referral to social agencies that can help the individual in selecting, buying and paying for food items or can give help by delivering these items.

Caregivers also should try to make sure that continuity of care is maintained if the individual has to move to another community. For example, a minimally-impaired person may find it difficult to manage in a house. He or she may need placement in a small apartment or in a senior citizen housing project. Unfortunately, uprooting often is accompanied by a breakdown in the continuity of care. To guard against this, those assisting in the change of residence should make sure that medical and other records go to the new practitioners.

It is important to give special attention to nutrition. An elderly person may need fewer calories than a younger person because of body and activity changes. But, all too often, the elderly individual does not get either sufficient calories or the right mix of food to meet nutritional needs. This may reflect a variety of problems, from difficulty in going to the grocery store to those of chewing as the result of poorly fitting dentures. The individual may need referrals for help with these problems.

If drug abuse and misuse is a general problem among the elderly, it is a pronounced problem among the impaired elderly. As noted before, several drugs may be taken at the same time for chronic illnesses, raising the risk of adverse reactions. A thorough review of the individual's drug intake is necessary.

To prevent complications of depression, it is vitally important to make early identification and treatment of physical causes of mental symptoms, and to give attention to drug-taking patterns. Some elderly persons are able to take impairments in stride, but others show considerable depression. It often helps if caregivers make clear to the individual that he or she will not be abandoned, that something can be done to make him or her comfortable, even if there is no cure for his or her conditions.

Symptoms of paranoia and guardedness do not necessarily mean that the patient cannot get along in the community. Many patients with these characteristics do get along given a small amount of support. The symptoms should not be accepted as normal because the person is old. They may be signs of early hearing or memory loss or other disorders.

Needs Assessment

Our focus here is upon the social support services necessary to help individuals remain in the community. In order to assess the need for these services,basic demographic information is necessary,including such data as that relating to household size and composition, home ownership, types and sources of income, marital status, age, sex, and occupational information. In addition, information gathered by or for the physician should cover diagnoses, dietary orders, weight, height, vital signs, allergies, drug intake and activity restrictions. A nursing assessment should include an evaluation of activities of daily living (e.g., ability to groom oneself, move and care for oneself), sensory impairments (especially speech and hearing problems), skin condition, personal habits, and evidences of mental illness.

A psychosocial assessment should be made including information about the individual's dependence on alcohol, other drugs, and tobacco. Observations of the individual's mental competence (noting any pathologic or behavioral problems) includingthe ability to cope with trauma and crises is valuable. A special note should also be made of household activities and how the individual performs them, with or without family and friends. Interaction with others should be examined, including the availability, reliability, and limitations of family and friends in the existing or potential support system.

The assessment should characterize the social and physical environments in which illness and disability may occur. Given such information, appropriate referrals can be made to home health, social, financial, and/or legal services. Additional referrals can also be made to senior

centers, groups providing home maintenance and chore services for elderly home owners, and to vendors of medical equipment and adaptive devices for home use. There would also be an advantage in early referral of family members and relatives to counseling and supporting organizations to assist them in their relationship and interactions with the minimally impaired older individual in their families.

To coordinate the referral process, a summary sheet may be useful for two immediate purposes: 1) it facilitates the arranging of referrals by a case manager, who by reviewing the assessment data, can judge the need for each recommendation and referral, and 2) the case manager can estimate the costs of the plan of care and can make arrangements for payment for services under Medicare, Medicaid, and federally-supported social services. Further, the case manager can give advice and counseling to the individual on the uses of private agencies.

Section 3. The Moderately-Impaired Elderly

THE MODERATELY-IMPAIRED ELDERLY

Who They Are

Persons in this group are unable to remain in the community without the help of others. They may require substantial but not constant supervision or assistance. A variety of health, social, housing, and other services can enable them to continue living outside of institutions in their own homes or sheltered housing. Typically, they are in their mid-70's or older.

This group includes persons: 1) who are capable of carrying out their major activity (in paid work or work around the house and in neighborhood), but are limited in the amount or type of activity they can perform; 2) who are no longer able to carry out their major activity; and 3) who have major difficulty getting around by themselves or need the help of others to do housework. Most often their impairment is basically due to advancing physical infirmities and disease.

Individuals in this group are no longer self-sufficient. An array of services is needed to prevent personal decline and to avoid long-term institutionalization for medical reasons. Because of their impaired mobility the services they require are most often given in their own homes. These persons also may be found in group residences, such as congregate housing and homes for "well aged."

Although not bedridden, such infirm persons may have heart failure, vascular problems, severe osteoarthritis or Parkinson's disease. They may be malnourished, debilitated due to slowly developing disease (e.g., peripheral vascular problems), or have suffered a mild stroke or amputation. In addition to restricted mobility imposed by these conditions, there may be impaired sight or hearing and impaired or slow understanding

or perception. A degree of memory deficit and mental confusion is common. These difficulties may puzzle them, their anxious family or friends, and practitioners. Under stress, these aged persons may become confused and bewildered. They may need supervision when they go outside, even in familiar surroundings.

With supervision or assistance, persons in this group can take care of some of their own needs and daily management. There need is for intermittent or continuing medical care and social protection. They usually require daily supervision at home, help to venture outside their homes (e.g., escort services), and often, directive advice and personal aid. Some persons may do better in protective living environments if they are willing to accept the lifestyle change and to give up their familiar surroundings, privacy and "independence." Sheltered group residences offer the same personal services these individuals would need if they remained in their own homes. It is a sensitive and important task to assist these persons to make decisions to move to a sheltered group residence. It is an equally delicate task to administer a protective residence in a manner that will preserve the person's sense of control over his or her own destiny.

However, most older persons in this group prefer to remain at home and continue their lifestyle with outside assistance. This lifestyle, it must be remembered, may be relatively isolated from the community, may be monotonous, and may separate them from stimulating experiences.

Financial and Personal Resources

Persons in this group are likely to be living at or around the poverty level, having exhausted their life savings. They comprise one of the most financially-needy and service-needy groups in the population,

often living in the most deprived circumstances and poor housing in run-down neighborhoods.

By and large, these individuals are found in families with below-average incomes. These low incomes tend to be less if the person is non-white, is much older than 65, and has a partial or major limitation of a primary activity. According to 1974 data, nonwhites tend to be in families with incomes below $5,000. The moderately impaired who live with relatives tend to have considerably less in resources than those who live alone.

People so dependent on others for fundamental necessities obviously require constant reassurance that they will receive them and the genuine concern of their protective service providers. They are perceived as, and feel like, needy dependents. Their "search for aid" becomes their prime motivation in relating with others.

Persons in this group have a fragile grasp on any permanency. Changes in health, in service systems, in housing, in funds, in family or friends generally presage a crisis or turning point in their lives. Any change threatens their curtailed adaptive capacities. They may experience uneventful periods, despite an accumulation of physical and mental deficits. But then, precipitated perhaps by minor illness or trauma, a crisis may occur. The crisis can result in the necessity for drastic changes in living arrangements, and can cause apparent helplessness.

General Needs for Services

Service programs for this group obviously focus on maintenance and supervision of physical health, the meeting of daily basic needs through help with meals or food preparation and housekeeping, with grooming

and other self care, and the reassessment of the need for changes in living arrangements as the environmental, health and interpersonal situations change. The need for counseling and reassurances also exists. Persons in this target group may require assistance with money management and with supplementary income to meet ordinary expenses.

In their own homes or in protective group residences, programs are necessary to compensate for isolation from family and community life, monotony, and removal from stimulating experiences and environments. In their own homes these individuals may use day care, escort services, homemaker/home service programs, visiting nurse services, regular counseling and case management services (e.g., protective care programs and "social guardians".)

Because of their precarious health, regular periodic assessments are necessary. These assessments should include medical consultation and a review of the individual's medication program. While survival as a functioning person may depend on such services, insurance programs do not usually pay for them.

As with other target groups, the moderately impaired are vulnerable to complications of their basic physical and mental problems. The patient with a poorly-functioning heart needs a program to prevent infection, trauma and other stresses. Illnesses must be recognized early before the patient requires crisis care in a hospital.

The health of those taking care of the patient at home also becomes important. For example, the illness of a helping relative may make continued home care impossible unless a social service organization provides assistance. These organizations may not move quickly enough to help or supervise the patient living alone. If the patient suddenly deteriorates,

an emergency requiring hospitalization may ensue. The lack of assistance and supervision may make admission to a nursing home necessary.

The combined use of institutional services and home care can benefit both the patient and his or her family. An adult day care center may provide social and rehabilitation services as well as supervision during working hours, thus freeing family members for employment. A day care program also can serve the family that needs a respite or vacation, by admitting the impaired person for a short stay.

The chief mental health problems in this target group are depression, acute brain syndromes, and dementia. The individual may recognize that he or she is on the borderline of needing institutionalization. The losses in functional ability may hurt one's self-image. The sense that everything is going downhill can be unbearable. However, the individual can be helped--and encouraged--if there are long-term-care options such as adult day care, home care, group housing, foster families and nutrition services. Where these options are unavailable, institutionalization may be the only alternative, even though a much less desirable one. It is important to provide the individual with professional assurances that he or she will be helped to maximize his or her abilities, that help is available, and that there is an advocate to assist in obtaining help. Many individuals want to discuss their personal life histories. These discussions with a sympathetic and probing person can help many older individuals to resolve conflicts and articulate the significance of their lives.

Interpersonal relationships tend to narrow into a less satisfying range of interchange involving fear of changes to come and of their capacity to retain their individuality and will. Mild depression of a chronic nature is almost universal and may become acute or deepen at times. When this

occurs, the depressed individual may require psychiatrically-oriented programs or treatment. The service program and its practitioners should always be sensitive to the individual's mental frailty, emotional vulnerability, and need for a reassuring, continuing protective relationship.

Assessment of Individual Needs

Whether the moderately-impaired person can remain at home depends not only on medical but also on social circumstances. The assessment effort here resembles that undertaken for the minimally-impaired, including a survey of the individual's environment, especially if the individual is homebound.

Beginning with the apartment or house and tracing the individual's ususal places of activity, the assessment focuses on such items as access to shopping, proximity to transportation, barrier-free entrances, mobility problems in the living areas of the home, security and safety precautions for utilities and fire safety, and convenience of bath and toileting facilities. Access to telephone (so the individual may readily call for help) is particularly important. The availability of helping persons--family members and neighbors, for example--also is noted.

The environmental assessment may prompt recommendations on activities, structures, and equipment to make the individual less dependent on others. The modification of the home environment may result in making home care feasible. A consulting occupational or physical therapist can be helpful in suggesting pertinent modifications. It is critical to involve family members early in the decision-making process for or against home care. Meeting the patient's needs depends on the reliability of the informal support system as well as professional services and environmental adaptation. An initial evaluation and periodic reevaluations of

professional services and interpersonal relations must contemplate two questions: (1) Are nursing and personal care services producing over-dependency? and (2) Are rehabilitation potentials being realized, so that the patient can take over aspects of his or her own care?

In order to make a comprehensive evaluation, a complete list of the patient's medical, nursing, and social problems should be drawn. An attempt then can be made to determine what home and community resources are available to meet the listed needs. Resources include the patient's family, attentive neighbors, medical and paramedical services, and community programs, such as meals-on-wheels and senior citizen centers. The meshing of needs and resources, often difficult, can prevent or postpone institutionalization.

A mechanism of reevaluation is required to determine how needs are changing, what resources become necessary, and what resources no longer are necessary. The team appraoch is invaluable making possible the use of new kinds of caregivers. For example, geriatric nurse practitioners, with physician back-up, may be ideal providers of care for the elderly because, as noted earlier, they may combine medical, nursing, and social service skills.

For the individual who lives alone but whose condition will require more and more assistance from others, an attempt should be made to plan for foreseeable needs. It is important the decisions about the possibilities of relocating to a congregate housing facility, obtaining supportive services, moving in with relatives, or of finding a personal-care home be discussed as options--not foreclosed decisions. The aware individual, regardless of physical impairments, has the right to decline any option.

The wishes of the individual to maintain a lifestyle must be taken into account by advisors whose recommendations can reflect candor as well as sympathy.

The advisor may perceive the older person's needs as a serious, frightening responsibility in the context of progressive decline. This is all the more true where there are communication problems between the aged person and the practitioner. A "primary" social guardian, a case manager, may be needed to take continuing responsibility for the individual and for liaison with other caretakers. (This personal guardianship system, usually the major function of the counselor or therapist, is not as yet a developed service responsibility in our communities, although group residences for the aged have been developing such programs.)

Relationships with the impaired person should be directed toward strengthening his or her self-direction and confidence in the competence and willingness of practitioners to help with decision-making. Too often, the "treatment" offered shies away from helping the individual come to terms with self and situation, helping him or her utilize the services system and programs most effectively, or aiding the person to choose among alternatives to meet changes in circumstances. If, at worst, the individual is immobilized by fear, the practitioner must win his or her consent or willingness to pursue the recommended actions designed to alleviate or minimize the effects of impairment.

Section 4. The Severely-Impaired Elderly

THE SEVERELY-IMPAIRED ELDERLY

Who They Are

By and large, they are the sick aged, usually in their late 70s and older. Their average length of life in an institution is from three to five years in some stage of worsening disability. They have such advanced and often painful infirmities of old age as crippling osteoarthritis, Parkinsonism, paralyses, cerebral vascular disease, and cancer.

Along with their advanced diseases and pain, these patients generally show chronic confusion or disorientation, depression or behavioral disorders. Of the one million older persons in nursing homes, an estimated 150,000 have serious organic brain disease. Their disabilities not only make them completely dependent on others but also affect profoundly their interrelationships with others, their mood, and their behavior. Because much of what is called dementia or senility reflects depressive effects of institutional life and/or overmedication, the magnitude of the true prevalence of dementia is not precisely known. Some observers believe that much of what is called dementia is actually untreated--but treatable--illness.

This target group requires a comprehensive program of care or supervision generally beyond the capacities of family or community-based services. The patients need organized assistance in such group facilities as nursing homes and chronic hospitals. However, illness does not always necessitate the institutionalization of severly-impaired persons. The interrelation of disease and environmental supports is critical to deciding when to admit an older person to an institution. It is possible to conceive of a severely-impaired individual who is sustained at home by family and home health care, and another individual equally impaired who is not

because the resources are unavailable or insufficient. The decision to institutionalize is not automatic; it is influenced by family and economic factors as well as the individual's health and motivation.

Financial and Personal Resources

Persons in this group have less income than the other target groups. Their economic resources are less likely to be sufficient for their basic needs. We have already noted that persons unable to carry on their major activities and persons who need another's help to get around tend to have below-average incomes. This is all the more true for the severely impaired.

The financial and environmental circumstances of the institutionalized aged have been studied more often than any other segment of our aging population. They are preponderantly medically indigent and must generally look for institutions that accept Medicaid clients.

General Needs for Services

The institutional program should include the full array of human-services. Home-like rather than hospital-like arrangements are preferable. Normal socialization activities and friendships need to be encouraged. Recreation and education often must be brought to the people, although it is wise to encourage sorties out into the community for those able. Stimulation and involvement in art, reading, crafts and other interests may make the difference between life and death-in-life. A relationship with a social work counselor who functions as a friendly guardian is important. The institution not only must provide expert treatment for the major illnesses but also must have a preventive medical program. For example, the partially immobile and sometimes incontinent elderly patient is highly likely to have skin ulcers. If the ulcers cannot be prevented, steps must be taken

for prompt treatment to avoid complications. A program of social stimulation--occupational therapy, friendly visitors, reality training and recreational events--is necessary to prevent or counter the depressive effects of institutionalization. A nursing home that seriously deals with these needs will try to resemble a home more than a junior hospital.

Institutional living tends to be a drastic change from previous living arrangements. The change from home to nursing home can be traumatic for many older persons, particularly since it occurs when the individual may be least able to deal with a crisis. Besides physical and mental disabilities, patients are burdened by separation from the community and family, by living with strangers, and by having to be dependent on attendants whose goodwill may have to be courted.

A program to combat the fear and bitterness patients may show at institutionalization is necessary. Recreational and socializing activities are essential, but not sufficient in the absence of a sympathetic and understanding staff. Personnel need training and supervision as well as peer support in order to be effective in working with patients and their many problems. Resentments between patients and staff can build up. It is critical for staff members to understand that the institution's goals is not cure but care--to assure the patient's comfort and support him or her to be as functional as circumstances permit. They must have techniques for assisting patients suffering from the depressive effects of institutional life--boredom, sex deprivation, and attnetion-getting through bodily complaints.

A word on patients' last days: As Dr. Robert Butler has said, control of pain and psychosocial help are essential at this time. To help the person come to terms with his or her life, to help the family work through

its grief, and to maintain sensitivity to individual patients' needs, practitioners need training in how to approach death and dying and in how to cope with their own fears and anxieties, which may be aroused by their patients.

Assessment of Individual Needs

The assessment follows the same pattern as for the minimally- and moderately-impaired, that is, a thorough medical, nursing, and social-work evaluation as a basis for deciding between institutionalization or equivalent services delivered at home. If care in the home rather than in the institution is chosen, a case manager is essential, so that services can be obtained from multiple sources and can be coordinated. In order to tailor changing services to changing needs continual attention should be given to the patient's rehabilitation potential and prognosis.

One reason for referral to a hospital or nursing home is the inability of home-care providers to offer the volume and intensity of skilled services required by the patient. Other reasons may be the cost of home-delivered services, the lack of a reliable support system, and the difficulty of making the necessary physical modifications to the home.

The assessment of an individual's changing needs should continue throughout the patient's stay in the institution. An expert, well-motivated staff will make continuing systematic evaluations of needs for medical, nursing, physical therapy and other services. The patient's morale also must be observed and be a matter of concern to those providing patient care.

Comprehensive assessment forms have been developed by such programs as the Duke University Medical Center and the Monroe County (NY) Long-Term Care Program, Inc. No single form would meet the needs of all types of programs. Readers are referred to the Administration on Aging, health departments, and home-health agencies for examples of assessment forms.

Section 5. Illustrative Cases

INTRODUCTION

The following five cases illustrate the differences in levels of functioning. They also call attention to the serious impact of one or two major stresses, or a series of cumulative stresses, upon the coping capacities and well-being of individuals in their later years. We begin with the older persons when they are self-reliant--still unimpaired--although each has problems. To show how either a major event or a series of mounting problems change their ability to manage independently, follow-up notes for each case are presented as of two years later. The process of increasing dependency is briefly described.

These cases are all presented in descending order of independence. However, all individuals in their later years do not necessarily decline. Some people may improve in aspects of their functioning, while others improve in some ways and decline in others. The following case examples serves as illustrations of changing levels of need--not as inevitable generalities for later life. They are also only outlines; they do not reflect the myriad circumstances of people. It is hoped that these illustrations may sensitize practitioners and planners to the needs for identifying functional levels of the elderly in health, psychosocial and environmental terms.

THE UNIMPAIRED STAGE

Mr. & Mrs. Cook

Mr. Cook is 70 years old, attractive, and vigorous. Until six years ago, the Boston resident was the hard-working owner of a successful apron manufacturing business. It had been in the family for several generations.

When the market declined, Mr. Cook decided to give up the business and retire at 64. He and his wife have been living comfortably on income from investments. There are two married children: the son, a surgeon; the daughter, a buyer for a department store. Retirement for the Cooks has been a period of physical activity, the pursuit of many lifetime interests (such as photography, stamp and coin collecting, and an tiquing), and travel abroad. In addition, Mr. Cook for five years has worked as a volunteer and service recruiter in a large chronic hospital.

This pleasant way of life has been interrupted by a recent accident: Mrs. Cook broke her hip. The son is active in her treatment. Delaying a trip to the Orient, the Cooks are confident of her quick recovery.

This couple's social and family life is vigorous. Except for the fractured hip, both are physically and mentally intact. They are able to cope with their problems. They have continued their standard of living; they direct their own lives and have found new productive and satisfying pursuits.

Aside from the medical attention, they ask for no community services.

Mr. & Mrs. Gaines

Mr. and Mrs. Gaines, aged 64 and 63, have lived on their five-acre farm in a Midwest community for 35 years. They have four married children, 28 to 39 years in age. Mr. Gaines was forced to retire prematurely from his engineering job on the railroad seven years ago because of a hearing loss and a hard-to-control thyroid deficiency. Mr. Gaines has periods of depression but manages to overcome them. Mrs. Gaines has not worked outside the home and farm since her marriage 41 years ago. She is overweight and has an "enlarged heart" but refuses medical attention.

When Mr. Gaines retired, the couple took in Mr. Gaines' 85-year-old mother, a disoriented person who required constant personal nursing until her death four years ago. This situation was hard on both Mr. and Mrs. Gaines physically and emotionally. They felt they had "done right by her."

They became foster parents for a children's agency six years ago. The rewards of this work apparently helped Mr. Gaines weather the strain of relinquishing work he loved and helped Mrs. Gaines endure nursing her mother-in-law.

They work the small farm, care for two foster children, and attend educational and social gatherings of the children's school. They also maintain membership in several farming organizations. Mr. Gains attends a railroad retirees' club. Their adult children visit them from time to time. Income from retirement pension, farming, interest on investments, and payment for care of the foster children yield a steady, adequate financial base.

Relieved of their earlier, harder struggles of earning a living and of responsibility for their own family, they enjoy an active social life and helpful relationships with young children. In spite of Mr. Gaines' health problems and hearing disability, his occasional depression, and his wife's heart problem, the Gaines feel they lead a satisfying life.

Mrs. Long

Mrs. Long, an 85-year-old woman, has been living for the past 10 years in her own fashionable cooperative apartment in New York City near her married daughter. She is the widow of a physician who died 25 years ago. She has adequate income from several sources. Her grandson has been staying with her for the past two years. After his college graduation, he had left his parents' home to pursue religious meditation and activities. His mother, Mrs. Long's daughter, is now dying of leukemia.

Mrs. Long has a number of physical as well as familial difficulties. She has undergone cataract operations and must use a cane because of her visual disability. Her defective hearing is inadequately helped by a hearing aid. She no longer travels abroad, feeling it is too much for her now. In spite of these staggering problems, Mrs. Long is considered by the people of the senior center where she has been active for almost a decade to be outstandingly independent and capable. She continues to have a number of interests, including reading, serving as the center librarian, and participating in discussion groups. She participates actively in groups, even the exercise groups; attends the center's summer camp; and utilizes the center programs extremely well. Her outgoing personality, her wit and her wisdom are so engaging that she was chosen by a television program as the star of an interview series on the center's activities. She performed magnificently. Her viewpoint is that, free of the yesteryear's social restrictions on wives, she can be an achiever, a coper--busy, lively, and high-spirited. She is aware of the admiration of others.

The stability of her situation is, however, "iffy," in view of her own increasing physical restrictions, the imminent loss of her daughter, and the instability of her grandson.

Mr. Gomez

Mr. Gomez, a 79-year-old Mexican-American, lives alone on his small ranch from which he eeks out subsistance. Rurally located, the ranch is 160 miles from a city in a Southwestern state. His 75-year-old wife, disoriented and physically disabled, has been in a state hospital near the city for 18 months. Because Mr. Gomez does not speak English well and fears contact with "Anglos," he has been unable to understand

fully his wife's condition or the reasons for their separation. He accepts the situation fatalistically. He visits Mrs. Gomez on those infrequent occasions when he is able to get a ride with his cousin, a farm laborer.

Physically active and strong, Mr. Gomez not only farms but also pursues his lifelong interest in music. He made a violin which he plays at the social events of a Spanish-speaking senior center and on programs for the elderly. As the elder of the community, Mr. Gomez has long enjoyed a position of respect, although some younger people scoff at him.

He drives his 1952 truck on familiar roads, but his poor eyesight makes this hazardous. Cataracts in both eyes are developing. A local doctor--who speaks only English--says the cataracts need to be removed. Mr. Gomez apparently does not understand the consequences of neglecting this condition. He does not follow up the medical advice, although the cousin urges him strongly.

Mr. Gomez misses his wife. He maintains himself and his home alone and continues his modest way of life with few changes. He has occasional periods of depression about his wife and some anxiety about his dimming eyesight. However, communal traditions and activities and the affection of his cousin's family help him to keep going.

Mr. & Mrs. Moore

Mrs. Moore, age 77, lives with her dependent husband, 79, in a comfortable apartment in a black community of Washington, D. C. They live on her pension, Mr. Moore's Veterans Administration benefits, and both of their Social Security cash benefits. The Moores married about 15 years ago when she was working as a secretary in a government office and he was a bartender at a private university club. He had worked

there and lived in their current apartment since his discharge from the Army after World War II. Mrs. Moore resigned from her job soon after their marriage to keep house. Mr. Moore has two children from his previous marriage; they are living in the city. Mrs. Moore had never married before.

About six years ago, Mr. Moore began to show signs of increasing loss of memory and emotional disturbances. Three years ago he was fired from his job. Shorn of work and familiar routines, Mr. Moore became even more agitated and depressed. Because of growing disorientation, he became dependent on Mrs. Moore for personal care and constant supervision. Mrs. Moore found caring for him not only onerous but frightening because Mr. Moore occasionally had violent outbursts, and because he was infuriated with his children who visited but took no responsibility for him. Mrs. Moore also missed being free to engage in community activities programs at the senior center. Her hypertension and diabetes intensified.

Two years ago, with the help of the counselor at the senior center, Mrs. Moore was able to place Mr. Moore in a day-care program for handicapped older persons. Although he is still disoriented, he has become more tranquil. Mrs. Moore has been relieved of considerable anxiety, and caring for him at night is generally uneventful. Mr. Moore appears happy to return home each day.

At this point, Mrs. Moore is functioning satisfactorily. Her illnesses have receded somewhat. She remains active and self-directing, has an adequate income, pursues enjoyable social and volunteer activities, and with the use of the day-care center, is able to fulfill her responsibilities to Mr. Moore.

THE MINIMALLY-IMPAIRED STAGE

Mrs. Cook

Mrs. Cook's recovery from her broken hip is not complete. In two years, she twice needed hospitalization for infection and for intensive rehabilitation. She was briefly disoriented while sick. At home she has needed more protection than previously: she finds it hard to join in travel, pursue her antiquing interests, or meet with friends. Turning fearful and depressed, she demands that her husband be with her at home, consequently he has had to limit his volunteer activities and other pursuits. Both Mr. and Mrs. Cook depend more on the children's assistance. All are frightened about Mrs. Cook's impairments and the future.

Mr. Cook's relatively monotonous duties frustrate him, particularly since they stand in the way of what he feels are more productive activities. He experiences anger and sorrow at his wife's incapacities. Mrs. Cook represses occasional anger at his never having helped at home. Her anger also stems from feeling that she must compete for his attention. At the same time she feels guilty and depressed.

The Cooks had not been prepared for curtailing their way of life. There have been high expenses for medical and domestic services, and for visiting nurses and rehabilitation treatments at home. Their outside social contacts decrease, but they ask friends in from time to time and still enjoy going out occasionally. Although now fearful of further illnesses, they have made adjustments to the current routines. Because it has been six months since Mrs. Cook was last hospitalized, their fearfulness has lost its edge. Mrs. Cook is beginning to perk up.

Although restricted physically, emotionally and socially, the Cooks are still directing the course of their daily lives, are able to arrange for personal and home services, can continue some enjoyable and useful activities with and for others, and can adapt to changing relationships with their children.

THE MODERATELY-IMPAIRED STAGE

Mr. Gaines

Two years after the original situation, Mr. Gaines' infirmities --his thyroid problem and hearing--have worsened. His chronic underlying depression seems more apparent. About a year ago he needed hospitalization for an acute episode. Because of his hospitalization and emotional instability, the foster agency has decided not to place any more children with them.

When Mrs. Gaines felt she could not continue a life on the farm six months ago, they sold the farm for a small sum and moved to an apartment in the community. Mr. Gaines is virtually homebound, going out only for visits to the doctor; Mrs. Gaines has curtailed her outside interests and activities somewhat as well as her household duties. She is restless and anxious about Mr. Gaines. Several months ago, Mr. Gaines--possibly reacting to antidepressants combined with alcohol--became disoriented, wandered out, and was lost temporarily. He is now ashamed to see his old railroad friends, has become isolated, and drinks heavily. Because Mr. Gaines can no longer drive, the couple's links with old friendship groups have weakened.

Their most important social occasions are visits from the children. The children differ on how to handle the situation. Exasperated with Mr. Gaines, they are worried about their mother. Because of the Gaines'

poor adjustment to the apartment, their lowered income, and more needs for support and help, a family agency has stepped in to give family counseling, coordinate medical and nursing supervision, and plan a treatment program for Mr. Gaines. The agency tries to help Mrs. Gaines with her fears about herself and her medical care.

Mr. Gaines has dropped out of the head-of-the-family role; his wife is now his protector. Mrs. Gaines copes but is discouraged and depressed. Both worry about their health, the future, and feelings of growing helplessness. Aside from their children, the family agency and community system of medical and other services are now the most important sustaining force in their daily lives. They are unhappy but grateful and responsive to the agency's continuing interest.

Mrs. Moore

In the year which has now passed, the Moore family has lost much of its independence. Mrs. Moore was hospitalized for two weeks with flu. During this time, Mr. Moore stayed with his married daughter at night. His tendency to agitation and wandering intensified at the day-care center. When he grew violent at being restrained, the center staff indicated they could no longer manage him.

Because of declining health and strength, Mrs. Moore was referred to a social worker for consultation. The social worker worked with the day-care center staff to reduce Mr. Moore's fearfulness and restlessness with techniques of reassurance. After Mr. and Mrs. Moore's medical needs had been assessed, homemaker and home health services were provided to assist Mrs. Moore. The social worker also arranged for periodic monitoring of the couple's conditions by staff members of the senior center, the in-home services agencies, and the day-care center.

Counseling by the senior center staff has helped Mrs. Moore to adapt to the loss of independence and to combat the depression and sense of helplessness over her physical impairments and the increased expenses for services. At the same time, Mr. Moore's family has been drawn into assuming protective responsibilities and for sharing in contingency planning if he needs more care.

THE SEVERELY-IMPAIRED STAGE

Mrs. Long

Mrs. Long's daughter died about six months after the situation as first described. The relationship with her son-in-law deteriorated. Her grandson and she help each other to bear their upset and grief. The grandson gradually changed his views on life with Mrs. Long's support, took some training, found work as a printer, and after a few months, left for another city. During this period, Mrs. Long continued to use the senior center but became less active and ebullient. She has found sympathy for her losses less enjoyable than admiration for her ability. When her grandson left, she began to feel weak. After a fall at home, she was unable to walk for awhile. She became frightened and depressed. She found the apartment too much for her. Her relationship with the center changed. Its members now help her with visits, counseling, and home-health aides. She is unable to direct the service program or control what they are to do for her.

Before long, her hearing became much worse. Her appetite decreased. Suffering another fall, she was confused and disorganized for a week, during which time home care was provided around the clock. Now she is frightened at the prospect of being alone at night. Although frankly dependent on the help and direction of others, she resisted their advice

to enter a nursing home which has strong rehabilitation program. When the allowable period for home-care services terminated, she had no alternative but institutional care.

Her entrance into the nursing home apparently destroyed her pride in having been a physician's wife, an independent person helpful to others, a leader with wisdom about life. Sometimes she imagines she is still living in her own home and that her daughter is alive and comes to see her. These periods of confusion terrify her.

Although her money assures her care, she is unable to buy back her health, spirit and independence. Mrs. Long is afraid of the nursing attendants, tries to jolly them along, and is well thought of as a result. Despairingly, she looks to infrequent visits from her grandson, to whom she writes. She is offended by her loss of status and self-direction. She keenly feels a loss of identity in this institution for the chronically ill and fears ending her life in a haze of grief, confusion, and longing for appreciation of what she has been and achieved.

Mr. Gomez

In two years, the situation for Mr. Gomez, now 81, worsened drastically. His wife died. His vision is almost completely gone. He cannot find his way alone outside his small house nor can he do the farm chores. He attends the senior center only when someone takes him. His cousin and cousin's wife find it difficult to do Mr. Gomez's daily chores, to bring him food, and to care for him because they are away at their own work all day.

Mr. Gomez continues to resist cataract operations. Neither the senior center nor the church has adequate outreach services to help him

with chores and personal care at home. The prospect of staying with his cousin means his being left alone all day in an unfamiliar house. It also means crowded living conditions and imposing on the cousin's scarce economic resources. There are no adult day care centers within reach of this community. Home health and home care services are lacking. Attempts had been made to transport Mr. Gomex daily to a day-care center 60 miles away, but the trip was too long for him. Feasible alternatives for meeting his needs are extremely limited.

An unnoticed and neglected leg infection became serious and he was rushed to the public hospital 160 miles away. Here it was discovered that he is diabetic. In order to avoid amputation of his leg, a prolonged hospital stay was needed. Because there are no centers for day care near his home and because he cannot be left alone at home any longer, Mr. Gomez was discharged to a public nursing home near his community. He is now completely dependent upon others for his care.

Chapter IV: Human Services: Structure for Delivery

Section 1. Services for the Well Aged

INTRODUCTION

Does the phrase, the very well aged or unimpaired elderly, imply that no services are needed while they remain in the "well" category? What are the criteria of "wellness"? How many older people fit that description? What are "preventive" and "enrichment" services and why are they necessary?

Only a small minority of older people are "well," if "wellness" is defined as the absence of disease. The vast majority of those 65 or over have at least one chronic ailment. At the same time, about four out of every five can take care of themselves. They have the capacity to carry out instrumental activities of daily living (such as shopping, cooking, household maintenance). Many, however, have an occasional acute illness requiring hospitalization or intensive care at home and convalescent care. They can then return to independent functioning. This volume has emphasized that level of functioning, rather than the diagnosis of disease alone, is the indicator of need for services. It is estimated that 25% to 30% of noninstitutionalized older people need regular services in order to remain in the community.

It is not possible to delineate the precise dimensions of the group who can be described as "very well," nor to use their wellness as the criterion of service need. Rather, the need should be viewed in the context of events that are "normal" to the well aged. The goals are prevention of premature or unneccesary declines and maintenance of health and well-being to the fullest possible extent.

Older people are likely to experience two kinds of stresses: those that are "normal" or intrinsic to aging and those that are imposed by the environment. All human beings experience "normal" life crises

that are developmental in nature (puberty, leaving school, marriage, bearing or fathering a child). These occur in a somewhat orderly and gradual progression. They are transitional for the individual (barring special problems of personality and adaptation) who masters each crisis and moves forward developmentally. For younger populations, major illnesses, interpersonal losses and other extraordinary crises generally take place one at a time. In contrast, the aging phase of life is often characterized by the relative abruptness, clustering, and interaction of age-related stresses. Most older people are likely to experience stresses intrinsic or often related to aging, such as declines in some physical and some mental capacities, chronic and acute illness, and personal losses (e.g., death of spouse, other relatives, peers, and even of adult children).

Superimposed are societal stresses: for some compulsory retirement, diminished income, loss of certain social position and roles, and barriers and hazards in the physical environment (such as inadequate housing and means of transportation and dangerous neighborhoods). "Intrinsic" and societally-induced stresses may interact so as to produce isolation and loneliness. Cumulative stresses may contribute to illness and even death.

Thus, it is safe to say that even "very well" functioning older people are at high risk, compared to younger people. It follows that preventive services to prepare and strengthen the elderly should go hand in hand with services and programs to ameliorate, as they occur, the "normal" and societally-induced stresses of aging.

Two other factors relate to the needs of the "very well" older person. First, the existence of any service structure, no matter how sophisticated and complete, is meaningless unless the older person in need is connected with it. The service must not only be available but also accessible and acceptable. Low utilization of even the most basic

entitlements occur without outreach and information and referral activities. Many eligible old people are not receiving Supplemental Security Income (SSI) because they lack relevant information or cannot deal with bureaucratic red tape and bias and a complex of services and entitlements that baffles even sophisticated professionals.

Secondly, many older people in our society suffer from the prejudice characterized by Robert Butler as "ageism." This prejudice is expressed socially or politically by assigning low funding priorities to services for the elderly. The accessibility of services may be reduced by complex eligibility requirements as well as low funding priorities. Administrators may lose enthusiasm in programs for the elderly if the program funds are insufficient. Older people themselves may express ageism. For example, because they view minor health problems as "normal" to aging, they fail to obtain health care. Or, their lowered self-esteem may likewise throttle justified demands for attention, care and services.

Human needs go beyond survival, subsistence, and medical care. The maintenance of "wellness" involves social needs. Related to "quality of life," these include interpersonal contacts and relationships with family and friends, recreational and occupational activities, religious activities, maintenance of roles, and a sense of mastery, autonomy, and some degree of self-determination.

Enrichment services have varied goals. Some aim at sheer enjoyment and companionship. Others offer an opportunity to pursue old or new interests, to maintain old roles or develop new ones, to learn, or to make contributions to others or the community. Enrichment goals are not yet fully accepted by our work-oriented society. Traditionally, we view recreation as a means of refreshment from labor rather than as an acceptable

end in itself. With more and more older people having more and more years of leisure, leisure-time activities should be accorded the dignity and status previously reserved for work.

HEALTH MAINTENANCE

In Volume I, we discussed health maintenance as a concept, touching on the various forms it may take. It was discussed primarily from the medical viewpoint. In this volume, as we discuss the needs of different population subgroups among the elderly, we will cover some of the same ground, but this time from the point of view of service providers in general. In doing this, we will illustrate some of the practical ways in which the health-maintenance concept can be applied. These applications will suggest how nonmedical service providers may advise, or in other ways assist, the elderly person to remain well. For example, a social worker who understands the relationship of clothing, exercise, and nutrition to health maintenance may be the most accessible person from whom the elderly individual can receive advice and awareness of possible problems. The elderly individual who lives in an underheated dwelling can be advised about hypothermia from a visiting social worker. (For a person with cardiovascular disease, an underheated apartment may decrease the supply of blood to the heart and increase the chances of a seizure.)

Every provider of service has a contribution to make to the health maintenance of the aging population. Based on a trusting relationship with individuals and families, a worker can influence health habits. The concrete knowledge a worker has about the conditions of life among the elderly and their families also can be communicated to the community to assist in understanding the need for health maintenance activities.

At this point, it may be best to define "health maintenance" in the context of varying degrees of impairment. The goal of practitioners is to help the individual attain and then maintain the maximum degree of physical and mental vigor of which the individual is capable. It is just as important to provide the individual with assistance in maintaining continued ability to handle stress and to make decisions important to his or her life. In short, we define good health in the context of the individual's actual and potential ability to function. An individual is not well if he or she is able but unwilling to perform activities beyond those necessary for basic living. Another individual can be considered well because he or she can only do that much and is doing it. If later life is to be satisfying, the aging person, service providers, and the community must be active in promoting or facilitating good health. This is the essence of health maintenance.

The judgment that an individual is as vigorous as he or she can be depends on a thorough professional examination. The practitioner must not automatically apply to the older person those health standards and goals appropriate for younger people. Too often goals are related only to the physical function, neglecting emotional and intellectual ones. Too often, the goals are defined in terms of limitations, neglecting the individual's capacities and assets.

In what follows, we will examine tangible and intangible factors contributing to health maintenance. This discussion will not be comprehensive. We hope it will sensitize practitioners and planners, thus enabling them in providing better programs, advice, referrals, and direct services.

Accident Prevention

Accidents represent one of the greatest threats to the well aged. Accidents are the third most frequent cause of death among aged males, the fifth among aged females. For every fatal accident there are probably 200 non-fatal but disabling accidents.

The automobile is the No. 1 villain--not to drivers but to the aged pedestrian. The second most common type of accident is falls. Sixty percent of these accidents occur in the home, most frequent of which is falling down stairs. Burns rank third, and are especially frequent among women.

The risk of accidents among the elderly is increased as the result of physical changes such as impaired vision and hearing, loss of the sense of smell, and slower reflexes. Older persons should be made aware of the possible effects of 1) their own specific limitations, and 2) how and where accidents occur.

Mobility

The ability to get about greatly affects the older adult's independence, feelings of self-esteem, and physical health. Mobility is essential to daily living and maintaining one's relationships with family and friends. Healthy people in their sixties and seventies are more frequently involved in highway accidents than are middle-aged persons, but they are safer drivers than teen-agers and many persons in their twenties. Although reflexes are often (but not necessarily always) slower, the elderly as a whole are safe drivers in the absence of a severe vision or hearing impairments.

Drugs and Medicine

Older adults often need to take medications regularly. Very often a single drug or even a complicated drug regimen makes it possible for the individual to lead a normal and productive life. However, there are certain major principles which the aged person should understand and practice regarding medication. For example:

- The patient should not hesitate to ask questions to be sure he or she understands the physician's instructions. The patient must let the physician know about any circumstances which might interfere with ability to carry out the instructions.
- The patient should avoid self-diagnosis and self-doctoring.
- One should take drugs only upon medical advice and under a physician's supervision, not on the "prescription" of friends and neighbors.
- One should carry in his or her wallet information about drugs or other special treatment being used, as well as the physician's name and telephone number.
- One should inform the physician of previous experiences with drugs, especially unfavorable reactions.
- One should discontinue immediately any medication which causes nausea, vomiting, hives, skin rashes, inflammation of the eyes, and exhaustion. These reactions should be reported to the physician.
- Medicine chests should be cleaned out regularly and old medicines discarded. All medicine bottles should be labeled in large, clear letters.

Family Relationships

Family relationships are important to health of family members. There are no specific rules about family relationships in old age. Rather, it is important to understand the specific needs and problems of unique individuals within the family. These factors should be considered in deciding the living arrangement of an older person.

Food, Nutrition, and Eating

Food is the object, nutrition is the biological process, eating is the social behavior. Each has a particular and vital role to play in the well-being of the aging person.

So long as a balanced diet is maintained, few changes in eating habits are necessary because of old age. Vitamin supplements are generally unnecessary. Because of metabolic rate changes with age, older persons should be encouraged to decrease meal size and increase the frequency of eating. Small, frequent meals may be better than the customary two or three large meals a day. Caloric intake should be adjusted to a level consistent with the degree of activity. The criterion for caloric adequacy should be an intake that maintains optimal weight, roughly the individual's weight at age 25.

Complaints of general weakness, irritability and other symptoms may indicate undernutrition, principally an inadequate intake of protein, calcium, and essential vitamins. Sometimes as a consequence of reduced income people tend to increase starchy, less expensive foods in the diet. In order to prevent or correct malnutrition, individuals should include an adequate supply of fruit, vegetables and milk in their diet; cook by boiling or baking; choose meats that are low in fat content; and avoid

foods that are difficult to digest (those that are fried, highly seasoned, rich in fat or carbohydrates).

Those experiencing a sudden and persistent loss of appetite should obtain medical attention. Poor appetite can often be related to the poor condition of the teeth or ill-fitting dentures.

Housing

Older persons prefer to remain in their own homes whenever possible. Often the exercise of a little imagination and creativity may make the difference between an individual being able to remain in his or her home or having to leave it. Sometimes, however, changes in living arrangements are necessary or desirable. An increasingly wide range of choices in living arrangements is being offered to the elderly through a combination of private and public resources. Low-cost public housing and government-aided housing developed by religious organizations, unions, and other non-profit gorups are available. Income is often the key factor in making decisions about housing.

Ideally, housing should be designed for the older person's living needs, safety, and convenience, as well as any special limitations or disabilities which the individual may have, such as cardiac or orthopedic conditions. Some elements of safety and design for older people's houses and apartments include:

- Rooms on one level, floors with non-slip materials, especially in bathrooms.
- Cabinets and closets accessible without use of stools or frequent bending.
- Telephones and buzzers in apartments to summon help in emergency.

Leisure

A key factor in maintaining the morale and positive self-image of the aging individual is satisfying and constructive use of leisure time. When the use of leisure time also involves some sports activity and exercise, it becomes an important contributory factor to promoting physical health. In general, there is a very strong relationship between good health and active living. This relationship should carry over from one's working days to one's retirement days. The meaningful and satisfying use of leisure is the means by which this carryover can be achieved.

More and more facilities, programs and resources are becoming available to assist older persons to meet their leisure-time needs. However, preparation for the satisfying use of time must begin long before retirement.

Mental Hygiene

There is no necessary parallel between chronologic and psychologic old age. The maxim, "You are as old as you feel or think," has much to commend it. Our society has come to accept emotional and other health problems as part of the baggage of daily living. Some older persons have mental health problems but hesitate to seek competent help out of a mistaken sense of shame or fear of being considered "crazy." They should be helped to accept the mental health problem as they would any other health problem. Self-depreciation, loss of appetite, insomnia (particularly awakening in the early morning hours) may be symptoms of depression. Many ostensibly psychiatric problems are caused by physical disorders.

The older person should be warned that self-diagnosis is dangerous. The individual should be encouraged to talk to a physician, who will either provide direct services or referral to appropriate sources for help. Sources of information and assistance might include members of the individual's family, community hospital personnel, and community mental health center workers. Ministers, rabbis, and heads of other religious groups may assist their elderly members who experience emotional problems.

Personal Habits

Personal health habits are developed early in life and generally do not change as one ages. Health education and group experiences can be used to encourage those personal habits which contribute to individual's well-being. Individuals can modify their mode of living and, in turn, affect their total adjustment to aging in a positive fashion. A continuing relationship with a personal physician and a regular program of physical examinations and disease detection are considered essential to good health. All practitioners should remind the elderly of this fact.

Physical Activity

Regulated physical activity is indispensable to a well-functioning body and should be encouraged. Exercise helps maintain the reserve power of the heart and lungs and contributes to general muscle tone. Endurance exercises (such as cycling, walking and swimming) are recommended. These should be undertaken regularly; the weekend or summer athletic programs could present a health hazard. Older persons should be advised to avoid exercise under adverse conditions such as extremes in temperature, after a heavy meal, or when one does not feel completely well. No activity should ever be pushed to a point of discomfort or distress.

Sleep

The amount of sleep required by an older person varies greatly. One's sleeping habits in middle age apparently carry over to old age; these need not be substantially modified. As a general rule, the individual should get enough sleep to awaken refreshed. Insomnia, a frequent and troublesome complaint, is most often the result of anxieties and emotional disturbances. Causes of insomnia should be ascertained and treatment measures should be instituted. The elderly should be cautioned against relying on sleeping tablets.

Smoking

There appears to be a relationship between smoking and lung cancer and some forms of heart disease. It is generally recommended that individuals of all ages stop or cut down on smoking. At the same time, emotional impact individuals experience when they stop smoking needs to be considered. The individual and his or her physician can decide whether the risks of continuing to smoke are outweighted by the emotional difficulties habitual elderly smokers might experience.

Summary

In general, it is recommended that practitioners discuss with older persons the need to:

1. Have periodic health examinations.
2. Eat a balanced diet.
3. Exercise in keeping with their capacities.
4. Sleep under conditions conducive to rest.
5. Refrain from harmful habits and excesses.
6. Avoid self-diagnosis and self-medication.
7. Maintain or develop leisure-time activities.

8. Maintain social interactions.
9. Accept themselves as they are, with their strengths and limitations.

FAMILY

The family is the primary source of services for older people when a problem arises. Only a very small percentage of older people initially turn to professionals for help. Therefore, families should be informed about services and entitlements and how and when to ask for them, not only for the older person's benefit but for others in the family. The spouse, siblings and even elderly "children" of an old person may themselves benefit from preventive and enrichment services. Problems of the parent generation may stimulate the adult child's anxieties about his or her own aging. Counseling the family and providing the adult children with entree to the service system can be a most effective means of prevention.

When an older individual is discharged from an institution, the existence of family does not necessarily obviate the need for community services. The returning person's needs may place stress on a spouse or a middle-aged or aging child, with potential for causing health or emotional problems. Assessing the needs of the family, as well as those of the returning older person, can set the stage for preventive measures.

With respect to enrichment, the role of the family is unquestioned. Apart from the instrumental roles they perform, family members are the confidents, the sources of affection, and the providers of the sense of security that derives from knowing there is someone who cares and who can be depended on. Much of the older person's social activities are family-

based: visiting or being visited, telephone visits, parties for birthdays, anniversaries and other events. For the 18% of older people who are childless, and for some of those whose children live too far away for the day-to-day contacts, interaction is necessary with caring others who are not family members. These relationships are facilitated by community services.

EDUCATIONAL PROGRAMS

Educational programs can serve major preventive goals. First, preparation for later life should begin in early life. However, the public school curricula typically ignore or distort the aging phases of life. For example, instructional material may describe older people as characteristically senile or students may be taught, contrary to fact, that the old are repudiated by their families. Educational efforts at all levels should aim to modify or eliminate ageism, convey a view of aging as a normal part of the life cycle, and impart factual information about the processes of aging and the maintenance of physical and mental health.

Pre-retirement counseling and education should deal with maintenance of physical and mental health, financial planning, living arrangements, and the psychosocial concomitants of retirement and the adaptations necessary. (Since the impact of retirement on the individual cannot be foreseen, counseling should be available to both spouses during the transition and until satisfactory adaptation has occurred.)

Older people themselves can benefit from health education, including information about good nutrition and the effect of drugs. Information about services and entitlements and how to go about obtaining them may be the most valuable benefit of an educational program. Most "very well"

older people need general or detailed understanding of Social Security, health-care benefits, Supplemental Security Income, Medicaid, veterans benefits, rent subsidies, and other programs.

The constructive use of leisure time is part of maintaining well-being and enrichment of life in retirement, a period sometimes as long as 25 or 30 years. Leisure activities should not be regarded as time-wasting and inferior to work. Counseling is helpful to allay the anxiety and apprehension that for some people may accompany retirement. A spectrum of leisure-time options to fit the diversity and heterogeneity of older people in age, socioeconomic background, preferences, and interests is needed.

Continuing education programs for older people can be found or established at schools, colleges, senior citizen centers, churches, neighborhood centers and other central locations. Some programs utilize the skills and experiences of the elderly as teachers. Older people may choose to engage in studying academic subjects, creative arts, or in problem-oriented group discussions of common experiences (such as widowhood, retirement and financial management).

Many colleges and universities have highly-developed programs for older adult education. Some offer reduced tuition in their extension and general studies courses. Others have developed second-career opportunities for retirees and "young-olds" who may want to work with older people in service programs. This latter curriculum may include courses in gerontology, covering the physical, social, psychologic and economic aspects of aging. Students may have opportunities for field work within operating agencies, such as senior citizen centers and area agencies on aging.

VOLUNTEER PROGRAMS

Other roles for the "very well" aged are available through volunteer activities, work options, and advocacy. Paid and unpaid volunteer jobs may be useful to the elderly. VISTA (Volunteers In Service to America) and Foster Grandparents (both of which provide modest compensation) and Retired Senior Volunteers Program (RSVP) are examples of governmentally-sponsored programs. Such programs all totaled serve fewer than 200,000 older people, however, they have been of great benefit to the participants. The special employment programs administered by the Department of Labor, serving even a smaller percentage of older people, provide another option for older adults.

The Foster Grandparents program, supported by grants to public and private nonprofit agencies, provides volunteer service opportunities for low-income older adults to "render supportive services to children," usually in institutions for the mentally retarded or temporary shelters for the neglected. The older volunteer receives a modest hourly wage. The Senior Companion program parallels the Foster Grandparents program, except that the target population is older adults.

Grants are made under the RSVP program for a wide variety of volunteer activities. Friendly visiting, escort service, hospital work, tutoring, and other usual volunteer activities are covered by this program. Compensation is limited to out-of-pocket expenses incidental to the volunteer activity.

VISTA, which grew out of the Peace Corps, offers volunteer service opportunities for adults in urban and rural poverty areas. Special settings, such as Indian reservations or mental hospitals, are also possible service sites. Compensation provided is primarily to cover modest living expenses.

In addition to the ACTION programs, the Department of Labor provides several employment programs. Under the Comprehensive Employment and Training Act (CETA), the department funds local governments in providing working and training opportunities for any person wanting employment. Employment and training programs targeted for older workers are available under Title IX of the Older Americans Act, which authorizes contracts for part-time employment in public service activities. The CETA program has a specific program for the aging group. Access to these programs may be through an area agency on aging or local public employment offices.

ADVOCACY/LEGAL SERVICE

A newly developing role for the well older person is that of advocate. The trained older advocate can help peers in dealing with the confusing multiplicity of entitlements, agencies, and procedures that stand in the way of getting benefits. Another aspect of advocacy lies in the organization of groups to press for social changes in such areas as tenants' rights, improvements in nursing home care, consumer fraud, and the like. The National Council on the Aging and the Grey Panthers are perhaps foremost among the emerging advocacy groups.

Legal services are available to the elderly whose rights are infringed. Supported by Federal grants to nonprofit organizations under the Legal Services Corporation Act, public corporations provide legal services for individual and class action law suits. Consumer activist groups work with these legal corporations on class actions to obtain authorized services and to champion constitutional issues.

INDIVIDUAL AND GROUP COUNSELING

Interpersonal losses (e.g., those of spouse, other relatives and peers) are experienced by almost all older people. As more people survive to advanced old age, more suffer the particularly poignant loss of an adult child. Whatever the loss, the comforting activities of family and friends can be supplemented by individual and group counseling programs. The elderly themselves can participate in helping their peers. Since most older people do not think of obtaining "outside" help in such crises, outreach is of particular importance.

A loss not often noted is that experienced by the well person whose spouse requires institutional care for a catastrophic physical or mental illness. Some well spouses describe this separation as more painful than a loss through death. At least one institution, the Philadelphia Geriatric Center, has developed a group counseling program for the well older adults who have institutionalized spouses.

Individual counseling is available in some communities through family agencies, such as the Family Service Agency, Catholic Social Services, and the Jewish Family Service. Federally-aided community mental health centers are required by law to serve the aged. Many centers do so by providing group and individual counseling. Public protective services also are available to help individuals and their families with elderly persons who have difficult behavioral problems.

INFORMATION AND REFERRAL, OUTREACH

Older persons come in contact with many service agencies, such as the Social Security Administration and Veterans Administration, Medicaid Agencies, senior citizen centers, volunteer and nutritional programs, and

public and private housing units. These points of contact provide opportunities to give information on resources. Area agencies on aging (AAAs) have undertaken to provide information and referral services in person, by mail, or by telephone with a well-publicized number. Some AAAs have computerized their lists of service agencies, so that a rapid response is possible to a telephone inquiry.

The hospital emergency room is an overlooked point of access to services. It is used increasingly, not only for physical ills but also for social and mental problems. Often, a sensitive reading of the presenting symptoms indicates a need to contact someone in the community who knows community resources and can link the elderly person to preventive services.

Many public, private and voluntary agencies that offer direct services or perform an information and referral function for the entire community can help reach older people. (In particular, the police are prime resources for reaching the troubled and distressed.) Individuals and groups can be instructed on how to refer the older people to preventive and enrichment systems.

The AAA network can be an effective framework for a viable outreach system by developing a continuous media campaign, publishing appropriate literature designed to inform gatekeepers, and advising specifically as to the entry points into the service systems. Senior citizen centers and Golden Age clubs are in a prime position to function as an intake point for service systems in health, income maintenance, housing, and other activities. Many senior citizen centers have undertaken programs to reach the isolated elderly through a variety of

community contacts such as the police, neighborhood grocers, barbers or beauticians, barkeepers and clergy. These resource people advise center personnel about older neighbors who have not been seen recently or who are thought to need assistance. The U. S. Postal Service has developed an alert system based on non-collection of mail as a sign that an elderly individual may be ill or in need of aid.

HOUSING PROGRAMS

Government-financed housing for the elderly takes many forms. Most programs are for congregate living. The tenants may qualify for rent supplements that make up the difference between the fair market rent and 15% to 25% of the tenant's adjusted income. Local housing authorities also receive federal aid for congregate housing for low-income families or individuals 62 or older. Rents in these units may not exceed 25% of the families' income.

Retirement communities and total-care arrangements are available to the elderly. The former are essentially housing developments restricted to adults. Some housing programs provide furnishings and security provisions. The total care communities offer contract to older persons to provide housing for life, meal and recreational services, and medical and skilled nursing care. Many of these programs are operated by religious organizations. A substantial initiation fee and a monthly all-inclusive charge are required.

Specialized housing for the elderly has spurred a trend toward including one or more services as an integral part of the living arrangements. Tenants vary in degree of "wellness." Sponsors of such housing programs face the problem of meeting service needs of tenants with various

levels of needs. These programs tend to have a high concentration of "well" older people. Thus, program staff may often provide information and referral for preventive service systems and deliver enrichment services.

CONCLUSION

A total community system should link physical health, mental health, social, educational, income maintenance, employment, volunteer, transportation, legal, and residential services. The special requirements of sub-groups should be addressed so that the delivery systems are consonant with cultural patterns, rural/urban special needs, and the unique requirements of ethnic and racial minorities.

Preventive service systems need to be flexible in responding to the needs of the ever-changing older population. These services should identify the older people who can benefit and facilitate their access to a wide variety of benefits and services, as their changing needs dictate. There should be (1) continuous review and monitoring of needs and services and (2) periodic assessments and reformulation of goals. A preventive system requires the support of other systems such as those for income maintenance, housing, health and mental health, vocational rehabilitation, and education.

Planning involves establishing arrangements for assuring the right service at the right time and place within an organization and providing effective interfaces with other systems. Because of the policies of service and funding entities, reinforced by a pluralistic political system, "integration" of services may often be undesirable and impossible to achieve. The more rewarding and realistic objective may be the achievement of a management capacity. Several managerial mechanisms are possible.

One is to establish a uniform data base to be used by all service entities. A single unit, then, is established to monitor various services and complement the standardized information system. This unit could be located at a multiservice center and assigned a catchment area. The monitoring function could be provided by an AAA through existing or new units or through other public or quasi-public agencies. The staff of the management unit would be responsible for assessment and/or service plans based on uniform data and procedures. They assure referrals which would maximize use of available services, monitoring service utilization, serve as the advocate, identify deficiencies and gaps in the service system, develop systems of affiliation or cooperative agreements, purchase services, and provide casefinding through an outreach program.

Wherever the well older person comes in contact with service systems, personnel should: (a) be alert to problems indicating the need for assessment; (b) have knowledge of the array of agencies and facilities that can perform that function; and (c) help the individual to connect with the appropriate service.

Enrichment services must be suited to the characteristics of older people. Their heterogeneity warns us against viewing any one program or approach as having universal applicability. Programs should be diverse to match the diversity of cultures and personalities in the population served.

Most gerontologists agree that, in general, older people fare best when activity can be maintained. However, some older adults prefer to reduce their social involvement. It is desirable neither to drag protesting older people to group activities and recreational events, nor to ignore them so they can quietly go about the business of "disengaging."

Finally, meticulous attention should be paid to the rights of older people for self-determination and choice. The provision of options enables all people, including older people, to have a sense of control over their lives. This is critical to the integrity of the human personality and to mental and physical health. It must be the underpinning of both preventive services and the enrichment of the lives which have been preserved.

Section 2. Services for the Minimally-Impaired Elderly

INTRODUCTION

Within the last 10 years, the implementation of Title III (Area Agencies on Aging) and Title VII (Nutrition Programs) of the Older Americans Act (1965 as amended), the implementation of Supplemental Security Income, the development of Title XX (Social Services Amendments) of the Social Security Act, the rapid expansion of the Retired Senior Volunteer Programs (RSVP), the development of Senior Aides, the introduction of Medicare-Medicaid, among others, have changed substantively the structure and type of services provided to older Americans. In addition to these federal programs, a group of mass-membership, politically-active organizations have emerged or increased in strength. These include: the American Association of Retired Persons-National Retired Teachers Association (AARP-NRTA), National Council of Senior Citizens, National Caucus for the Black Aged and the National Association of Retired Federal Employees. All have experienced substantial increases in membership. AARP-NRTA alone has some 8 million dues-paying members.

An apparent result of these public and private efforts has been to slow down an historical trend toward more and more institutionally-based services for the elderly. Although not new, having begun in the Middle Ages in Europe, community-based services that reach into the home are receiving more public and financial support.

This section discusses ways in which some services are delivered in the community for the minimally-impaired elderly. It also offers observations about the structure of the delivery system as it affects this group.

Minimally-impaired persons may need one or more services, such as housing, transportation, supportive reassurance, advice on planning, per-

sonal counseling, part-time housekeeping and chore services, help in finding or buying access to community services (e.g., information and referral, financial supplementation, nutrition programs, recreation or educational resources), and continued, intermittent or periodic health services at home or, more likely, at a doctor's office. Persons with work skills may need aid in finding part-time employment.

In general, the need for more than one or two continuing services is unusual. More likely, the need is for an immediate, short-term purpose, such as occasional counseling on legal needs or to strengthen family bonds and solve family frictions. These are essentially self-directing persons; they can generally make their needs known and seek out assistance from family and friends to deal with contingencies. Most important is assurance that help is available if needed. Comfort and convenience in daily living become more important to these elderly persons than when they were unimpaired.

Nonetheless, they may come to depend more on others' initiatives than on their own if they become less sure of themselves. At the same time, there is a tendency to embarrassment over having to depend on relatives or, even more so, to depend on service agencies. They tend to be concerned about the esteem of others and are fearful of losing rights to self-management if they become more dependent.

The service provider must be on guard against providing assistance in a manner that depreciates the client. Rather than becoming encouraged by such aid to continue or even improve in their social functioning, individuals may become depressed or resentful. Practitioners must be tactful as well as technically skillful or they will be unsuccessful in their attempts to promote the client's independent living.

In the face of noticeably eroding self-reliance, self-confidence in managing their own affairs, and self-assurance in making decisions, tactful personal counseling is almost always needed. Fortunately, where only one area of function may be mildly affected, repair of this fragile element by supportive or rehabilitative services and programs will strengthen all the other functional areas. It may not take much to restore the individual to independent living. This is true even where some thinking difficulties are present. For example, the person with minor but irritating forgetfulness can be shown how to arrange memory aids, such as keeping keys on hooks near an entrance and storing a duplicate set with a neighbor. Or the individual with arthritis of the hands may need devices for manipulating hairbrushes and car keys. Small aids may produce big differences in satisfaction with self and living, and they may also prevent complications of depression and poor self care.

In sum, timely provision of services of even the most modest kind can improve the quality of life for the minimally impaired. Services succeed best when delivered with a sense of the person's rights to the service and pride in his or her own competence.

We will turn now to innovative programs that have these objectives.

HOUSING

For older persons who attempt to remain independent in the community, maintaining their own residence is a major problem. Most older people reside in single-family dwellings that they own. While high ownership rates among older people may be desirable, deterioration of the buildings is a nagging problem. A common complaint to adult service workers is that "I just can't keep the place up anymore." Older people find they often lack the ability or the funds to maintain their own property. This

may be frustrating because of sentimental attachment and pride in the home. More importantly, deterioration may produce hazard to life or limb. A partial solution for elderly homeowners on low income appears to be a home repair service.

One such program, the "Handyman Project" in St. Louis, Mo. involves 20 mobile handymen. They make minor home repairs for families with limited income. In 1975, these retired workers served over 500 clients, 56% of whom lived alone in their own homes in 20 municipalities. The project reported that both client and worker satisfaction was high. Some 68% rated the handyman service as excellent. The most low cost, limited home repair requests (ranked by volume) were for plumbing, electrical work and carpentry. (The basic charge was $3 plus mileage.) In a second project of this program, the "Fixit Workshop," older men meet weekly to repair small household appliances brought in by customers. (Average cost of repair, $1.25.) Both projects exemplify how older workers with skills can schedule a certain amount of work and still engage in leisure activities.

In Albuquerque, N.M., four agencies cooperated to develop a home repair program for elderly Navajos. Although limited to a "winterization" project in 1976, the effort met an immediate need of older Indians living on a reservation. Using on an average about $100 worth of materials per unit, younger workers put in weather stripping, replaced window panes, fixed leaky roofs and repaired doors.

Working out of a senior center, Marines from Camp Pendleton near Fallbrook, Calif., do yard work, home maintenance and minor repairs for older people in the community. In Central Oklahoma, older men with

construction skills provide other older people with needed home renovations. Four men with a combined age of 300, an average age of 75 years, constructed a kitchen for the Edmond Senior Center.

On a larger scale, the Home Repair Program in the Virgin Islands, begun in 1975, is using older workers and younger apprentices to repair dwellings of homebound elderly people. The program's major goal is to allow minimally dependent older persons to continue to reside in their homes even when they are unable, physically or financially, to make the necessary home repairs. The program involves several agencies: (1) homemakers in the Title III project who refer clients, (2) the Community Self-Help Housing program estimates what the needed repair would cost, (3) the Comprehensive Employment and Training Act (CETA) pays the wages of older workers, (4) the Youth Commission program pays the wages of the younger apprentices, (5) the Department of Public Works provides technical assistance and other help beyond the scope of the project, and (6) the Commission on Aging coordinates all activities, recruits older workers, purchases materials, pays for travel and pays the wages of the coordinator through a model project grant from the U.S. Administration on Aging (AoA). Within a year, substantial renovations had been completed on five homes and, in February, 1976, new projects were started on the islands of St. John and St. Croix.

Older persons in need of adequate housing may find few alternatives available to them in their communities. The sheltered housing program of the Maryland Office on Aging is a promising alternative for minimally dependent older persons. The Maryland plan, enacted in 1976, authorizes the Office to develop and certify sheltered housing based on approved standards and guidelines. The law defines sheltered housing differently

than institutional care so that it is not subject to the licensure of Maryland health care facilities. In the sheltered housing concept, meals, light housekeeping, and personal services are provided in addition to residence. For people 62 and over who have temporary or periodic difficulties with activities of daily living, the Maryland plan offers help in performing those personal and household functions necessary to maintaining independence. Some 1500 sheltered housing units are expected to be in operation in Maryland by 1982. Dr. Matthew Tayback, State Director on Aging, describes the program:

> Sheltered housing for older people is different from housing for independent living and from institutional living. Although many facilities for independent living provide some services for individuals with limitations, they are primarily directed toward providing shelter and not to providing a total living environment for the older person. Conversely, institutional care facilities do offer their residents help with daily living, but their emphasis is on maintaining a designated level of care rather than providing assistance to support independence.[1]

TRANSPORTATION-MOBILITY

Transportation for the elderly has been a major problem, particularly in rural areas. Many older persons live in rural areas where the number of cars per capita is less than the national average and public

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[1]Thomas, Dawn F. Maryland Pioneers: New Concept in Housing. Aging, February-March, 1977.

transportation is less well developed than in urban areas. Many counties have no organized transportation service. A neighbor, relative, or friend may often charge a high fee to transport an older person.

As a result of inadequate transportation services, low income elderly persons spend a disproportionate share of their limited income for minimal transportation services. Studies in various states in 1971-72 revealed that transportation and its attendant costs consistently ranked as one of the three most important social problems of older persons. Typically, a low income older person spends $10 per month or more for transportation, yet will average fewer than two trips per week. Top travel priorities are to health services and food stores, and a major determinant of travel behavior is auto ownership. The poor and the aged travel less and miss more services than do more affluent and younger people.

To address this problem, the State of West Virginia in 1974 developed the Transportation Remuneration Incentive Program (TRIP). The aim is to provide 133,000 needy elderly and handicapped persons with an $8 transportation ticket book each month. The user pays from $1 to $5 for the book, depending on household income. The average charge was slightly over $3 for an $8 ticket book. TRIP tickets, worth 25 cents each, may be used for public and private carriers, including buses, taxis, and van services provided by social service agencies. Once providers of transportation are approved for the program, they collect tickets from riders, turn them in to the Department of Welfare, and receive the full face value. This program is noteworthy for building on existing resources and rewarding those services most responsive to older persons' needs. The similarity of the TRIP transportation delivery system and the Food Stamp delivery system is not accidental; West Virginia pioneered both programs.

Most urban areas have public transportation, but it is not always accessible. Where access to low cost and reliable transportation is lacking, many lower and middle income urban elderly have trouble obtaining food, clothing, medical attention, and social services. In some cases, the difficulty results in premature institutionalization. Where public transportation is available, there may be cost and other barriers to its use. The physical design of the transportation vehicle, carrier routes and pick up times, the availability of low cost demand-response systems (taxis, vans), and possible injury (muggings, robbery) may deter the urbanite from using public transportation.

Ways of making public transportation more responsive to the needs of the elderly have been tried in various locales. One development is the "kneeling" bus. The Central New York Regional Transportation Authority serving Syracuse and Onondaga County purchased 10 buses that "kneel," lowering their front step, to facilitate boarding and alighting by elderly and handicapped persons. On most buses the first step is about 14 inches from the pavement and about 10 inches above most curbs; a "kneeling" bus lowers its first step to within seven inches of the pavement and almost to the curb. In Philadelphia, the Southeastern Pennsylvania Transportation Authority modified the regular buses to "kneel." The buses also have large air cushion bumpers on the front and rear ends; in the event of a low speed impact, the jarring is lessened, a helpful feature for older and handicapped persons who may be in the aisles.

The U. S. Department of Transportation (DOT) is aiding manufacturers in designing and testing bus prototypes adapted to the elderly and handicapped. One type has a hydraulic lift and another has a moving entry ramp, both designed for the moderately handicapped person. Under the

Urban Mass Transportation Act, DOT is funding technical studies for states and sub-state regions to determine the needs of elderly and handicapped persons. DOT also provides grants and loans to public and private agencies for developing transportation services for elderly and handicapped persons where mass transit is unavailable or inappropriate.

These activities reflect an agreement signed in 1974 between DOT and the AoA to improve transportation services for the elderly and handicapped. The agreement, designed to coordinate the use of federal funds available under the two separate acts, does little or nothing for the rural elderly.

In St. Petersburg, Fla., where every third person is 60 or over, a project called TOTE (Transportation of the Elderly) is serving 30,000 older and handicapped persons. Eligible riders have access to minibuses that offer door-to-door service, nominal fares (35 cents and 60 cents) and transportation by advance reservation, weekly subscription, or telephone request as well as charter service. In Missouri, the Older Adult Transportation Service (OATS) is a door-to-door bus network operating in 80 of Missouri's 114 counties. Some 10,000 people are enrolled in the 48 bus system, and pay a moderate annual membership fee plus a contribution per mile traveled.

Similar programs have been developed in many urban communities, often funded through AoA or ACTION. These programs have catchy names such as "Seniors on the Move," "Off Your Rocker," "Wheels to Meals," and "Dial a Ride." Funds have been available for purchasing vehicles, but securing funds for maintenance and replacement remains a nagging problem. Community service agencies increasingly are aware that vans equipped with wheelchair ramps or lifts are badly needed to replace partially or to complement fixed seat vans. Riders' fees, agency resources, and local government funds are insuficient to replace these vehicles.

One approach to the problem of limited mobility is to bring services to older people rather than transporting them to the services. In late 1975, Boston based a mobile market and transport program for the elderly on a Denver prototype. Under the M.O.B.ile Market program, any Boston resident 60 and over may shop from a 31-foot refurbished van, stocked with 250 grocery items. Originally developed as an anticrime device to help the elderly avoid muggings and purse snatchings, the market makes 31 regularly scheduled stops at public housing and inner city locales where concentrations of older people are found.

HEALTH CARE

The minimally-impaired person is vulnerable to episodes of acute illness. These may require brief institutionalization. There are risks in institutionalization if a plan of care is not directed toward restoration of the individual to community life. The preventive and health maintenance issues for the minimally impaired may be summed up as (1) attempting to prevent acute illness, (2) minimizing the residual effects in terms of health and lifestyle, and (3) restoring the individual to his home with the greatest degree of functional independence attainable.

We also have seen in earlier discussions in this volume that individuals may lose their independence for reasons other than illness, for example, because of the loss of financial and social supports. The current discussion of the minimally-impaired is in the context of findings that a significant proportion of patients are in nursing homes because of social and financial, not health, problems. Steps to be taken for the minimally-impaired must be timely and effective to prevent premature institutionalization. This is why it is crucial that health maintenance, screening, and treatment services be offered in settings in or near the resident of the

community living elderly, with linkages to social services. Following are several examples of how this can be done.

A swimming exercise program for older persons can be found at the Community Center in Cohoes, N. Y. Here some 30 persons from 62 to 80 years old are involved in a "drownproofing" and exercise program. Prior to activities, blood pressure, heart, and lung function are checked to assess participants' endurance and strength. Non-swimmers are taught to swim, but the ultimate objective is to improve muscle tone rather than swimming ability.

A mobile health screening unit in Arkansas, Project MERCI (Multiphasic Examinations to Reduce Chronic Illnesses) utilizes a converted 66-passenger school bus. Staffed by a registered nurse, a licensed practical nurse, and a laboratory technician, it brings medical aid to the rural elderly. The medical staff administers tests for lung capacity, vision, blood and urinary problems, diabetes, and coronary disorders. Results are forwarded to the State Department of Health for review by physicians. If the results indicate that the older patient should contact a doctor, his or her personal physician or another appropriate doctor is notified.

"Senior Citizen Health Fairs" are becoming popular. The Stamford (Conn.) Health Activities Program for the Elderly (SHAPE) was responsible for bringing together dentists, physicians, ophthalmologists, chiropractors, podiatrists, optometrists and other health personnel to administer some 4,000 health tests free of charge. The SHAPE staff also followed up by scheduling rechecks and referrals to doctors for those with abnormal test results. Transportation was provided by a bus company and by minibuses from

community agencies. The Salvation Army provided sandwiches and the students and faculty from the high school arranged and hosted the event.

In San Francisco, the University of the Pacific School of Dentistry uses an 18-passenger van equipped with hydraulic lift to shuttle patients from senior citizen centers to the dental school for low cost dental treatment. Believed to be the first of its kind in the nation, the program provides comprehensive dental care with emphasis on replacing missing teeth.

In many urban communities, home health agencies are available when the minimally-impaired person has an episode of acute illness, injury, or accident. Rural areas tend to be underserved by these agencies.

The plan most suitable for the elderly is a system offering different levels of care in the home. Services provided by such a system might include: (1) home visits by physicians; (2) visiting nurses; (3) home health aides; (4) homemaker or other essential services; (5) prosthetic devices and other medical equipment; (6) transportation to clinics and other essential needs; (7) meals on wheels; and (8) hospital based home care.

SOCIAL SERVICES

A major goal of the Older Americans Act was the development of the Area Agencies of Aging as a strong coordinating arm for the delivery of social services. This goal has not been realized to the degree envisioned by Congress. A comprehensive and integrated social service system for older people in the community does not exist in most rural or urban areas. As the older person experiences growing loss of function, reliance on the social service system increases. Yet the system has tended to become more and more impersonal or bureaucratized, dealing with only a part, or only a time-linked problem, of an individual. To the

minimally dependent elderly, service fragmentation imposes not only a drain on limited energies but also enhances fears of what will happen when further functional loss occurs. The availability of a case manager with ability to coordinate services of various agencies would be enormously helpful to these elderly.

In the current overworked and underfunded social service system, the minimally dependent elderly tend to be served only after the more severely impaired. Often, however, a relatively small investment of time and effort by an agency can be highly productive with this group of elderly people. If one central problem can be resolved, others may clear up, too. This is especially true where the problem is nonrecurring. Widowhood, loss of friends and family, and relocation are major but manageable events if handled in a timely, humane way. Flexibility must be built into the social service system to respond appropriately and quickly.

A problem commonly cited by older people is the lack of an appropriate liaison or contact in a specific agency. Most service workers are already overburdened with excessive case loads. However other individuals in the community can be trained to perform some of the information and referral functions. In the recent past in rural areas and small towns, individuals working on "listening and linking," becoming aware of an older person's problems and then trying to find some agency to do something about them, were generally ineffective. Nevertheless, the Colonial Club in Madison, Wis., has enjoyed some success by employing persons to serve in a broker role as knowledgeable friends for older people. People in the community who are known, trusted, sociable, and aware of appropriate liaison personnel in service agencies can serve in a "listening and linking" capacity.

CONCLUSIONS

There is an insufficient number of social, health and other supportive services for older people. The service programs we have reviewed are more innovative than commonplace. However, they illustrate features valuable to the minimally dependent elderly. The home repair program in the Virgin Islands is an excellent example of interagency cooperation, albeit in a tiny activity. Such cooperation organizes the system for the individual, rather than requiring an individual, who must overcome physical impairments, information gaps, and/or articulation deficits, to do the organizing. The concept of using human services in a preventive way to resolve problems before they enlarge is particularly appropriate to serving the minimally dependent elderly who may not realize they have (1) a soluble problem and (2) services available. Obviously, no human service can be broadly effective when potential clients do not know it exist. The need for outreach is evident. Nor can a human service be effective if the impaired person is unable to reach practitioners because transportation is poor. These elements, applicable to the elderly with large or small impairments, should be carefully considered in any attempt to provide service.

Section 3. Services for the Moderately-Impaired Elderly

Noninstitutional community services have long played a major role in the care of the aged and disabled in Great Britain and Europe. By contrast, the United States has had relatively few alternatives or supplements to institutional services. These have expanded in recent years. Now, however, the stage seems set for the development of community services for the elderly, especially those with a moderate impairment level.

Three categories of community services for them will be discussed in this section: 1) health supportive services, 2) social supportive services, and 3) environmental supportive services. The discussions under these headings proceed with the understanding that these are not rigidly divided; some approaches in one category may include elements from another.

HEALTH SUPPORTIVE SERVICES

Adult Day Care

Adult day care--sometimes called "adult day health, " "adult day treatment," and "therapeutic day services"--is a rapidly emerging mode of care. It is designed to provide health restorative services, health maintenance services, or protective services for specific populations. In essence, it is a program of ambulatory services offered on a regular basis to individuals who do not require 24-hour institutional care and yet--due to physical, social and/or mental impairment--are incapable of fulltime independent living.

Health-oriented adult day care begins with patient assessment and plans of care, based on recommendations of the participant's physician and developed by the program's multidisciplinary team. The program provides, in addition to psychosocial and nutrition services, the following services:

-- A time-limited program of intensive restorative services for the post-hospital or post-nursing-home patient who needs continued therapy; and

-- Long-term health maintenance services to a high-risk population eligible for institutional care or likely to become eligible soon if health monitoring and supportive services are not provided.

The psychosocial program for the frail elderly emphasizes socialization and maintenance of proper nutrition in order to prevent or retard mental and physical deterioration, which may result from biological aging and social isolation. The programs often make it possible for the family members who work to maintain their elderly relatives at home.

An indication of the rapid growth Adult Day Care is the fact that in four years, between 1974 and 1978, the number of identifiable programs grew from 15 to 300. Many more are planned.

Reimbursement for services presents the greatest hurdle to expansion of adult day care. Although reimbursement for health-oriented programs is possible through Medicaid (Title XIX of the Social Security Act), relatively few states have released funds for this purpose. The notable exception has been California. In 1977 it passed legislation to make adult day care a required service in its Medicaid (MediCal) program. The legislation called on each county to develop plans for this service based on determinations of actual need. Services are to be provided by nonprofit organizations under a community-based advisory board.

The greatest catalyst in developing adult day care has been support by provisions of Title XX (social services) of the Social Security Act. In any state, use of social service funds for adult day care is contingent on the state plan including an adult day care program as an optional service. It should be noted that reimbursement for adult day care program through

Title XIX and XX is limited to persons meeting means tests. A smaller number of programs serve private-pay persons. In some instances, particularly in programs funded by philanthropic groups, a sliding fee scale is used.

Although these programs have evolved considerably, much knowledge remains to be gained about assessment instruments, admission criteria, staffing patterns, transportation, costs and reimbursement patterns, and physical facility requirements.

Home Health Care

Home health services have been used in this country for many years to enable individuals to remain at home. Their use frequently has prevented the need for institutionalization. A stimulus to the development of a broad array of home health service providers came in 1965 with passage of the Medicare law (Title XVIII of the Social Security Act). The legislation provided, for the first time, entitlement to home health benefits for the population aged 65 and over.

Home health services may be defined as those that may be brought into the home, singly or in combination with other services, in order to achieve and sustain an optimal state of health, activity and independence for individuals who suffer from acute illness or chronic illness and disability. The services covered under Medicare illustrate the variety possible through home health programs: part-time skilled nursing, physical therapy, speech therapy, occupational therapy, medical social services, home-health-aide services, and certain types of hospital equipments. Upon physician's authorization, the Medicare beneficiary is entitled to 100 visits in his or her home by the staff of a certified home health agency. Similar benefits are available under Medicaid. (The current Medicare benefit is complex: under Part A, or hospital insurance, the beneficiary is entitled to 100

posthospital visits in a spell of illness; under Part B, or supplemental medical insurance, 100 visits are allowed in a calendar year without prior hospitalization. A controversy about home health coverage under Medicare stems from the fact that Medicare is basically designed for acute rather than chronic illness.)

Mini-Clinics

These are found in housing for the elderly or in multiservice senior centers. As a preventive health service and as neighborhood clinic, they are designed to provide on-the-spot assistance for groups of the elderly in areas distant from, or poorly served by, conventional providers of primary health care.

Nutrition Programs

Title VII of the Older Americans Act, which supports transportation and social programs, also finances provision of hot meals at nutrition sites. A major Title VII objective is to get ambulatory persons to places where nutritional and social needs can be met through a congregate meal. Meals can be brought directly to a person's home by a "meals on wheels" program. Usually, a paid cook and/or dietician is responsible for food preparation and often delivers the meals. Many elderly persons are referred to nutritional programs by lay and professional persons, especially home health and social work personnel. But many of those most in need are ignored unless there is an active outreach and referral effort.

SOCIAL SUPPORTIVE SERVICES

Homemaker/Home Health Aides

These services are becoming increasingly important in the nation's health care resources. The homemaker/home health aide assists in the care at home of (a) the acute and chronically ill, (b) the disabled and lonely,

and (c) the frail elderly. As a member of a supportive services team, the aide plays a major role in carrying out a plan of care designed by professional personnel and supervised by them.

The aide provides a variety of services to help the individual maintain and increase his or her level of functioning, ease the loneliness of the isolated person, and maintain the home when a family member responsible for care is hospitalized or disabled.

Home health aide services, in some respects, differ only administratively from homemaker services. The former are services given under the rubric of "health" services. The latter are provided by, or through, social service agencies.

The Senior Center

Senior centers, or multiservice centers, originally were established in settlement houses or in community centers. The William Hudson Center of the New York City Department of Public Welfare, one of the first multiservice centers for older persons, offers social, recreational, cultural, educational, and health services under one roof.

The senior center has become a facility in its own right and a home base for older persons. Currently, Title V of the Older Americans Act funds the development of centers. Centers can become a focal point not only for the well elderly but also for the impaired, provided they offer health services (e.g., the mini-clinic). There are an estimated 5,000 or 6,000 centers in the United States, some offering comprehensive services. Those that do not are diversifying gradually. With increasing awareness of the importance of providing services to older people within their neighborhoods, centers may incorporate the variety of efforts mentioned for the Hudson Center.

Telephone Reassurance Service

This service is often linked to a senior center or volunteer group. Through periodic telephone calls, a check is made to see if the elderly person at home is all right or if emergency help is needed. The "cue check" gives the elderly person, especially if homebound, an opportunity to reach out to others. An adaptation of this service is an emergency alarm system, "Life-line," pioneered by the Boston University Gerontology Center and the Hebrew Rehabilitation Center for the Aged in Boston. A mechanical device allows an older person to activate an alarm signal at a central station; an operator there provides help in emergencies. The device provides the older person with the reassurance of knowing that there is access--at the bedside, via a portable trigger--to emergency aid when it is necessary.

Peer Group Outreach

Elderly volunteers. This form of social supportive service involves elderly volunteers as casefinders. Serving as "buddies," social group leaders, and friendly visitors, elderly volunteers are effective in encouraging and comforting their age peers in dealing with the problems and opportunities of old age. Volunteers of any age are a major source of outreach manpower. Besides finding the elderly who need services and then referring them to providers of health and human services, the volunteer directly assists the older person simply by being a "friendly visitor," someone who comes for a chat and socializing in the home. Sometimes, the roles of friendly visitor, homemaker, and chore service provider are combined.

Other Social Support Services

These include counseling by public or private social agencies (e.g., a department of public welfare or a family service organization), and by social workers employed in housing units or in senior centers.

Although older people are expected to come to these agencies, some organizations have experimented with outreach counseling by social service personnel who go into homes, sometimes in league with health and home care professionals.

ENVIRONMENTAL SUPPORTIVE SERVICES

Housing Programs and Semi-Institutional Alternatives

Housing for the elderly may incorporate physical and social support mechanisms. The array of services in congregate housing goes far beyond provision of a common room for socializing. The system of services may embrace outreach efforts for social and health programs on the premises. There may be a connection with a social service and a health agency or a hospital through a "hot line" telephone. Congregate housing also may offer some nursing care. Thus, special housing for the aged may include programs ranging from minimal support services to comprehensive services, not only providing residents with meals and housekeeping but also medical supervision and recreational activities. The more comprehensive the program is, the more the housing arrangement resembles shelter care.

Foster homes, group homes, and halfway houses are examples of semi-institutional alternatives. These facilities take care of functionally impaired and disabled patients during the working day. In doing so, they allow families to keep working during the week, with a sense of security that their impaired elders are being cared for.

There are also "respite programs" which make it possible for two or three generations to live together despite difficult circumstances. At times of particular stress, older family members are admitted briefly to these facilities (e.g., day hospitals) so that the family may rest and

recover. Respite service can be provided in the home by day and night sitters, available when the family wants to go out for shopping or visiting or when a family member needs time off from caring for an older person who needs inordinate attention at night.

Foster homes are for those aged who need a protective or sheltered environment with a family other than their own. Foster home placements are ideally suited for those whose personalities thrive in a family but not in an institution. However, these arrangements are hard to make because few families are willing to take in an outsider, especially one who is mentally disoriented.

Group homes provide a setting in which a group of older people share housing and meals. Some group homes are managed by commercial firms; others are managed by the residents themselves, dividing the expenses and alternating on chores.

Protective Services

This is a label for a group of services for mentally deteriorated or disturbed persons who are unable to manage their affairs and who have no relative or friend to act in their behalf. Determining whether a person is unable to act responsibly and is harmful to himself or herself and others presents complex legal, medical and moral issues. These may have to be settled in court, with the elderly person represented by counsel.

OTHER CONSIDERATIONS

This brief review has covered only some of the spectrum of services for the moderately-impaired elderly. Services mentioned in connection with the unimpaired and minimally-impaired elderly also are useful for the moderately-impaired and have not been mentioned in this section. However,

it should be noted that the moderately-impaired obviously benefit from access to programs and services through a suitable transportation network. Buses that can accommodate wheelchairs and individuals with canes certainly extend the mobility of many elderly people.

Mental health services hold an important niche in the assistance system for the elderly. These may be utilized to a greater extent if given in nonstigmatizing settings, such as senior centers or housing projects rather than mental health clinics. Efforts to link older people with welfare agencies may be far more effective if the services are provided in more neutral or less threatening settings such as senior centers and housing projects. Information and referral centers can be a base for a central "supermarket" of service representatives in places readily accessible to the elderly. One of the best ways to mesh multiple services for the impaired person is through case management, discussed elsewhere in this volume (e.g., Chapter II).

In the next section of this chapter, we will look into the institution. We may mention here that institutions themselves can provide outreach programs aimed at preventing premature institutionalization. The Philadelphia Geriatric Center and the Hebrew Rehabilitation Center for the Aged in Boston provide a continuum of services for older people. Both have established housing programs that meet needs of people at various levels of care and link them with the centers' own nutrition, medical, recreational, and social services. In some areas, the physical embodiment of the continuum is a campus on which are located a congregate housing project, a senior center, a nursing home, and a rehabilitation facility. They may be close to a hospital. Plans for such a development have been

made in the Washington, D. C. area by the Greater Southeast Community Hospital. Its geriatric center also is to have a training facility for long-term care and home care practitioners.

In summary, major problems in serving the moderately-impaired elderly concern 1) the linking of services and their coordination, 2) mechanisms to make services available and accessible before a crisis intervenes, 3) information and referral, and 4) transportation to places of service. A final emphasis here is the need for a "trigger mechanism"--some community agency or institution--to activate a service network for the impaired person. It must be kept in mind that, under certain conditions, institutionalization may be the only feasible and humane alternative. Thus, while we work at improving services in the community, efforts must be directed at making institutions for long-term or terminal care responsive to the ideals of human dignity and to sound health and social standards.

Section 4. Services for the Severely-Impaired Elderly

INTRODUCTION

The people seeking long-term institutional care are usually older, sicker and poorer than the aged who remain in the community or those receiving noninstitutional services. During the last 40 years, three major scientific and technologic breakthroughs can be identified as having contributed to the current status of older people in need of institutionalizaion.

The first, in the 1930's and 1940's, was the conquest of infectious diseases by the use of antibiotics. The advent of sulfa, penicillin, and the "mycins" brought under control pneumonia and urinary tract and post surgical infections.

The second, in the 1940's, was the revolutionary methods used in orthopedic medicine and the growth of rehabilitation restoration, physical medicine and therapy. New surgical techniques and hardware made possible repair of broken hips and bones.

The recognition and subsequent usage of psychoactive drugs was a major contribution in the 1940's. Mood-altering pharmacology made possible the management of those suffering from mental conditions often found in older persons. Those who previously could only be cared for in mental hospitals could be helped in other institutions or in the community.

These and many other discoveries ultimately meant that older people could live longer, albeit with chronic illnesses. The inevitable consequence was the growth of their needs for temporary or permanent care in a protective and congregate-living arrangement.

As new treatments became available, a health crisis depleted not only the physical reserves of older people but also their finances. Responding to the greater numbers of older people in need of health care, the federal government created Medicare and Medicaid. Medicare, for

Social Security retirees, was designed to provide for acute care in the hospital, post-hospital care in an "extended care" facility, physician services and certain home health benefits. Medicaid, for those who met a financial test of need, had similar benefits but also covered long-term care.

Once the government policy determined that it would pay for care, then it followed that there should be some criteria for what was good, appropriate, even "quality" care. Because models for long-term care were lacking, it was easier and more expedient to adopt a "medical model" for care and payments, even though the patient needed psychosocial and other nonmedical care. Thus, institutional services now are provided in skilled nursing facilities where the primary emphasis is on medical and nursing care, and intermediate care facilities which provide limited nursing services.

There are several ways to discuss institutional services; perhaps it would be helpful to view them as clusters. While they can be described in this fashion, there is an interface between the services and some overlapping occurs. It is within this framework that services for persons needing institutionalization will be reviewed.

REHABILITATION

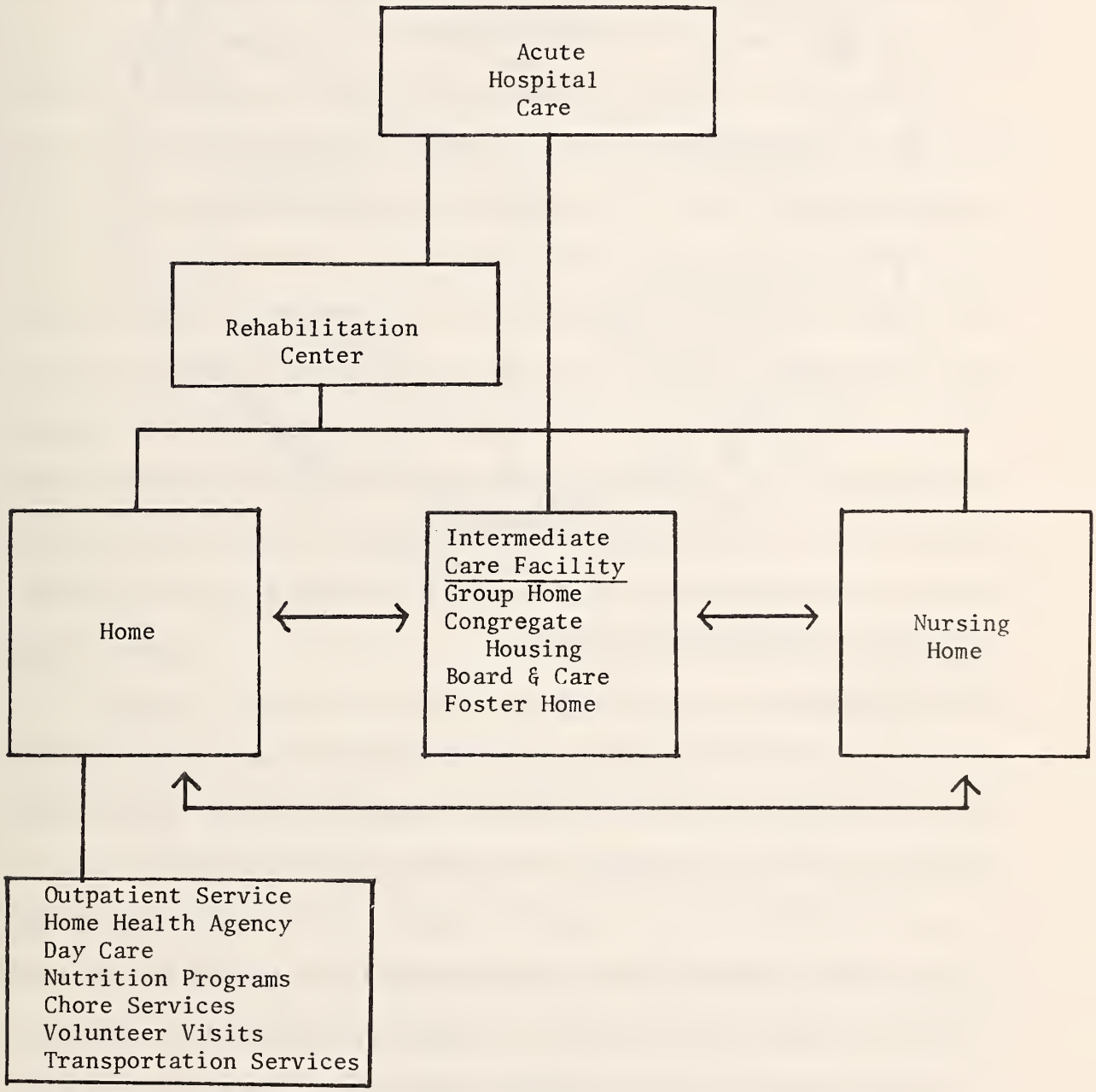
Rehabilitation services can be delivered at facilities such as nursing homes, acute medical facilities, rehabilitation centers, or in the patient's home. In their broadest sense, these services attempt to restore a person to the highest level of independent function he or she is able to attain in the context of illness or disability and psychosocial circumstances. The most common geriatric rehabilitation problems involve stroke,

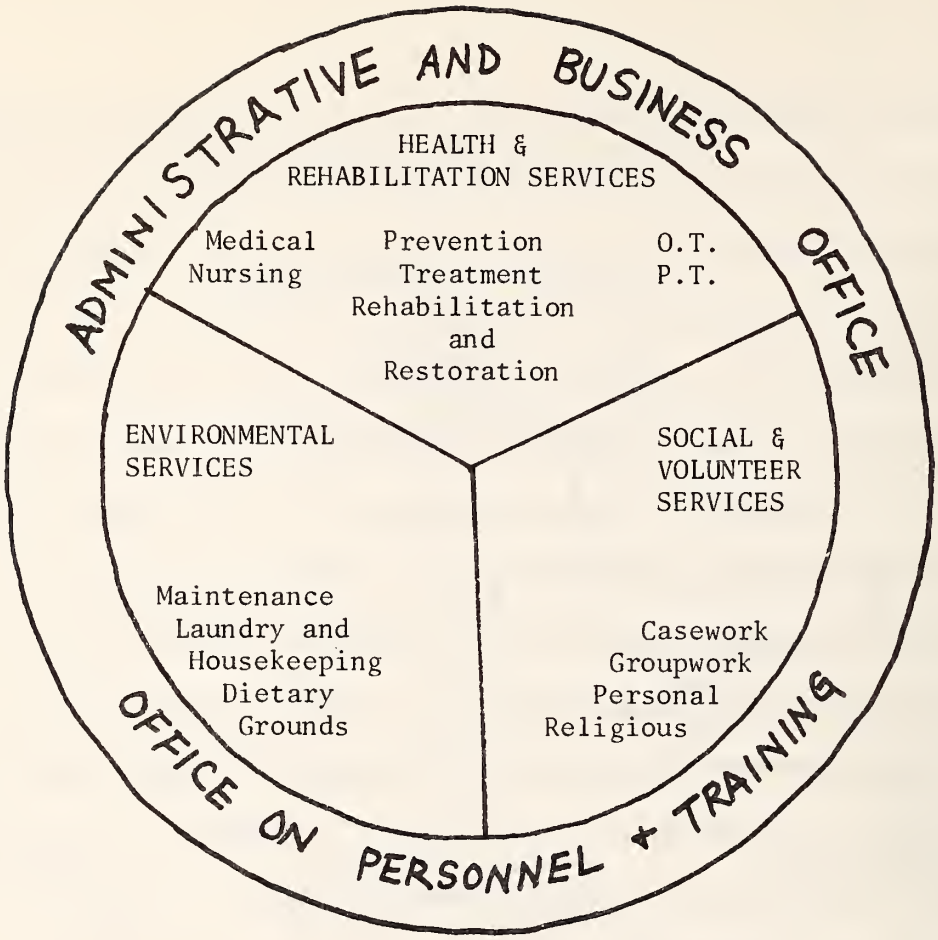
arthritis, hip and leg fractures, and combinations of these problems. The patient is expected to participate actively in the treatment program, being asked to dress, come to meals, and practice the skills necessary to various kinds of activities. The rehabilitation team may consist of not only the physician, nurse, and physical therapist, but also the occupational and speech therapists, social worker, and psychologist. The patient's morale and resocialization are major concerns of the team.

In selecting the site for rehabilitation, consideration must be given to the patient's and family's capacilities. Where family support is poor and the physical disability substantial, an inpatient setting is probably the best choice. Where family support is good and the physical disability not so substantial, the patient might do best at home, with utilization of day care or outpatient hospital facilities (if he or she can be transported) or of a home health agency (if homebound). The chart below shows the discharge options relative to levels of care.

Rehabilitation, in sum, is a process of resocialization and the learning of skills to compensate for disabilities. Relatively small improvements in a patient's ability to compensate for disability may make a large difference in quality of life. It often means the difference between larger and smaller degree of dependency, between confinement to wheelchair or bed and ability to ambulate, which may allow a sense of self-reliance. Rehabilitation approaches should be universally available as a part of all geriatric care.

Structure of Rehabilitative Care





STRUCTURE OF INSTITUTIONAL SERVICES

Administration

The figure above depicts the clustering of institutional services. The outer ring of the "pie" represents the administrative and business services, as well as personnel and personnel training services.

The administrator is usually responsible to a board of directors (if the home is nonprofit) for the operation of the agency and its components. The administrator, a full-time employee, coordinates the entire program of services for the residents and staff. The administrator is responsible for the preparation and implementation of the home's operating budget in cooperation with the board. He or she is expected to keep in close contact with developments in the fields of aging, welfare and health.

The bookkeeping or accounting department operates under the administrator and in consultation with the fiscal officers of the board. Some homes utilize a purchasing officer who is responsible for all purchases. Still others use a financial administrator to oversee the fiscal operation. An office on personnel and training maintains employee records and prepares required reports. Some homes do not have a separate personnel office; hiring, reporting and employee record-keeping is done by each department.

The home may have a department covering functions of inservice training, continuing education and staff development. It also is responsible for coordination of the education program for the home; orientation of new employees; reviewing and recommending teaching materials; assessment of educational needs and development evaluation procedures; and cooperation with appropriate resource agencies (universities, colleges, school systems) to promote/develop programs of basic and continuing education for personnel.

Health Services

Medical. Various patterns exist, depending on auspices, history and local conditions; however, two patterns predominate. One is the open medical staff, where individual physicians follow their patients in nursing homes. The second pattern is for institutions to have a staff physician or physicians.

Effective January 2, 1976, all homes designated as skilled nursing facilities in the Medicare and Medicaid programs must retain a medical director. The federal regulation, aiming at improving patient care, specified this physician as responsible for the medically-related practices of the facility and for its obligation to provide appropriate medical care. For many facilities, this was a totally new concept; for others, the requirement reinforced customary practices.

The medical program of a skilled nursing facility usually covers prevention (health maintenance), treatment (curative), and rehabilitation (restorative). Its goal is to permit the individual to remain as active as his or her situation, condition and desire permit. A facility may offer all or some of the following services: pre-admission history and physical examination, including psychiatric evaluation, of each applicant; yearly physical examination including electrocardiogram, chest film and lab work for each resident; regular check-ups by physician, consultant, dentist and podiatrist, as necessary; and family conferences when indicated. Referral may be made to outside specialists in ophthalmology, dermatology, hearing and speech evaluation, urology, orthopedics, gynecology. The facility may have a licensed pharmacy on the premises. It must have an agreement with a hospital for transfer of ill patients.

In intermediate-care or health-related facilities, the pattern of medical services is usually different; many of them have no medical director. Each resident is under the care of his or her own personal physician.

Nursing. The nursing staff in a skilled nursing facility applies the principles and procedures of nursing to fit the special needs of the elderly around the clock. The staff includes: a nursing director who is usually a registered professional nurse (in some states, a licensed practical nurse can be designated director if a registered professional nurse is available as a consultant); nurse supervisors (usually professional registered, but may be licensed practical); licensed vocational nurses (usually utilized as medication nurses); nurse aides and orderlies (personal care to residents); and a medical secretary (medical records, Medicare claims and billing).

Occupational Therapy. Many homes have an occupational therapy (OT) department that offers a program of functional and supportive therapy. Under direction of the registered occupational therapist, purposeful craft activities are provided to residents with specific mental and physical disabilities. For the other residents, OT has a diversional goal of furnishing meaningful activities essential to good health. (As a motivational factor, craft items made by residents may be sold at a home and at sponsored sales.) A work project or sheltered workshop may be designed to provide residents with opportunities for activities which will maintain and improve self esteem.

Residents with specific mental problems can receive individual OT sessions to meet defined needs. Classes in reality orientation may be given daily by the staff to improve or maintain the confused resident's orientation to the world around him or her. Sensory stimulation classes may be conducted for the residents who are severely mentally impaired to help increase their awareness of taste, touch, hearing, sight and smell.

The OT department staff usually assists in retraining residents in activities of daily living, such as dressing, combing hair, brushing teeth, and eating. Residents who have suffered a stroke or loss of a limb usually can be taught to compensate for the loss of function. The resident can be trained to use the non-affected limb and to strengthen its fine motor coordination. The occupational therapist may employ a wide range of adaptive devices (plate guards, rocker knives, reachers, invalid cups, long-handled shoe horns, etc.) to help residents better perform activities of daily living.

Physical Therapy. Homes may have a professionally-trained registered physical therapist. The therapist provides programs of exercise for muscle retraining, strengthening and rehabilitation for the physically impaired. The physiatrist (specialist in physical medicine) evaluates, prescribes, orders and consults on all patients referred to his service. The PT program includes functional and passive therapy, utilizing ultrasound, paraffin bath, hydrotherapy, full body immersion in a whirlpool tank, hot packs, parallel bars, shoulder wheel, finger board, walkers and permanent steps.

Social Services

Homes may have a social worker who processes applications for admission to the facilities and offers casework services. These applications usually are precipitated by a crisis in health, finances, and/or family affairs. A professional evaluation of need is important. The social worker develops rapport with the family members or other party responsible for the applicant to determine their feelings concerning the proposed placement. The social worker often helps with interim planning if immediate placement is not possible.

Through skilled interviewing processes and casework understanding, the social caseworker helps the individual resident to work through personal or interpersonal problems and assists the resident in adjusting to group living. When needed, counseling may be also given to the resident's family and relatives. Through consultations with professionals in other disciplines, the social worker may coordinate and conduct group therapy sessions.

Recreation

Coordinating and leading the recreation program is the task of the group worker. He or she may meet with a resident recreation committee

to plan programs, present dramatic skits, and develop a monthly calendar of events. The group worker develops both small group and mass activity programs, works with volunteers, and collaborates with the occupational therapist on specified projects. Because group living produces intensification of interactions among persons of varied physical condition and level of functioning, group work services may be crucial to the atmosphere of the home and to the satisfaction of those residents with special problems and needs.

Regardless of the full array of the physical equipments, life in an institutional home can be devastating, dreary and dull without a variety of activities to satisfy the diverse interests of residents. Examples of regular weekly or monthly activities include literary and dramatics groups, current events discussions, games, movies, concerts, and parties. Joint programs with community-based Golden Age clubs and bus outings also are beneficial.

A recreation program must gear itself to the different functional capacities of residents in the following categories: the "well and ill" ambulatory; the chronically ill, and the mentally confused. All residents should be encouraged to participate in some program. The program should be flexible, varied, and inclusive enough to appeal to and stimulate the residents. It is important that recreational activities be modified to accommodate to the changing needs and decreasing functional capacities of residents. The fundamental importance of recreational programming should be recognized. It is not frill or "show" or substitute for medical care but essential to a good adjustment and a satisfying life for residents. Recreational programming should follow certain principles:

-- Programs in which the residents themselves take part are far more valuable to the participants than programs put on by others for the "dear little old people."

-- Nothing of interest to an adult is alien to the program in a home.

-- Services mean nothing without a caring relationship.

-- The information on the specific problems of older people in the home helps in effective programming.

-- Basic social work principles apply: 1) recognizing the rights of individuals, 2) accepting group members for what they are, and 3) beginning at the level of the group.

Increasingly, other categories of human services workers are found in institutions -- recreation therapists and activity therapists.

Volunteer Services

Volunteers help make a nursing home a "home" by their direct contact with residents. They act as friendly visitors, casework aides, and recreational leaders. To help preserve the dignity and integrity of the older person, volunteers may need supervision, training, and recognition of good work. Assignments should take into consideration the talents, interests and abilities of the volunteers, as well as the needs of individual residents in a home for the aged.

Religious Services

To meet religious needs of residents, the home should consult the clergy of the community. The staff should not impose religious observances or beliefs on residents who must be free to attend or not attend religious services available in the home.

Personal Services

Space should be provided for an adequately staffed barber shop and beauty parlor. If space for these services is not available in the home, there should be adequate transportation to barber shops and beauty parlors as well as to other servicesin the community. Provision should be made for receiving and mailing letters and packages. The resident should be able to receive and make telephone calls.

"Hotel Services"

The dietary service has a strong therapeutic component. Individual dietary patterns are inextricably bound up with individual preferences, life experiences, cultural factors, physical conditions, and regional and religious practices. A major difficulty in designing and operating food services for the older person in long-term care is that of accommodating divergent expectations and demands. The menu must be nutritionally adequate, varied, and appetizing. Substances that are hard to chew and increase the risk of choking should be avoided. Therapeutic diets are prepared for residents who need them, such as diabetic patients and those for whom salt is harmful. Special diets--bland, mechanical, pureed, soft and for tube feedings--are prepared for the acutely and chronically ill, at the direction of the physician, and under the supervision of the registered dietitian.

The housekeeping department is responsible for cleanliness of rooms and halls, floors, windows, and furniture and for linen supply and laundry. Close attention is paid to disposal of waste, pest control, and measures to assure good hygiene. Inspection and maintenance of the home's facilities and equipment is a routine process. Daily routines include care of residents' rooms, laundry and personal services.

The home's physical plant requires constant and expert care, and a full program of preventive maintenance, regularly carried out. The maintenance department is often responsible for the security services.

THE FUTURE OF INSTITUTIONAL SERVICES

Part of the spectrum of providing long-term care in the community includes long-term care in an institution. The difference between institutional and home care lies in the fact that the person's own home and family resources are inadequate to the person's needs. We should not make the mistake of thinking that long-term institutional care exists solely until we develop and build up more in-home and other community services. The future surely holds a place for institutions. The issue lies not in whether they will be needed but in how they will be integrated into a network of in-home and other services.

Section 5. Death and Dying

The hospice is a new kind of institutional facility providing service to the terminally ill and his or her family. The hospice movement and hospices have developed as the inadequacies of hospitals and nursing homes in dealing with the emotional needs of many terminally ill patients and their families have become increasingly evident. Within the hospice walls and through its outpatient services, the organization is oriented toward helping the patient come to terms with death, to find meaning in his or her life history, and to overcome loneliness and pain. Patients bring their own furnishings and pets to the hospice room. Emotional interactions among patients, staff and family are encouraged; they may cry together, touch each other, and exchange joys and confidences. It brings together groups of older people to share experiences and thoughts about dying, in hopes that they may find a resolution to doubts and fears. The hospice also relates to the family's mourning; it aids families to mourn and resolve their grieving.

Patients are attended by doctors, nurses, social workers, ministers, and volunteers. These service providers recognize that where the hospital is oriented toward curing the patient, the hospice is oriented toward emotional support and relief of pain. They have experience and training to assist dying patients. They also are prepared to deal with their own fears of death and dying. Consequently, the hospice staff is able to accept many patients' desire that no heroic measures be taken to prolong a life that has lost its meaning.

Section 6. Case Study: Neighborhood Senior Services Program

The following report is presented to illustrate a program which succeeded in integrating the formal and informal support systems. However, this presentation does not imply that the program described here is the only or the best one which aims towards this goal.

* * * * * * * * * * * * *

Neighborhood Senior Services (NSS), formed in the fall of 1974, organizes neighbors to provide supportive services for older residents. While there have been many programs serving the elderly in neighborhoods, there are few which actually organize a group within a specific neighborhood. This approach was proposed by a staff member in the Institute of Gerontology at the University of Michigan. Work study students in the school's social work program and staff members from the county council on aging looked for a neighborhood that could sustain a group concerned with services for the elderly. The first NSS branch served an area of about two square miles, containing 5,000 persons, including 400 older people. The neighborhood is mixed in terms of income and race.

Twenty-five residents, many of whom are retired, constitute the membership. There are some middle-aged and younger participants. The members volunteer to make their neighborhood a more attractive place for elderly residents. They believe that neighbors understand the needs and desires of their older neighbors. In addition, the information gained through serving individuals could be useful in improving the services delivered in the neighborhood.

The new organization meets regularly to discuss projects to be undertaken by the group. Policy is set by consensus of the active members. New projects are introduced at a regular meeting and discussed by those present. If the project fits into the overall NSS structure and members are willing to work on it, it may be adopted as an NSS project. The project must benefit residents of the area and meet the standards set by the membership. Although the organization has close relationships with many agencies, it is autonomous, reports to no other organization, and includes no agency representatives.

The group's first task was to identify persons over 65 in the neighborhood. The voter's registration list provided names of those persons born before 1910. This basic list was expanded by referrals from church groups and community leaders. The list, cross-referenced by name and by address, provided the basis for establishing communication with older members of the neighborhood. The use of the list, however, was restricted to NSS.

During the fall of 1974, the organizing group met monthly in each other's homes. Early in 1975, meeting space was secured by a member in a school building. In 1976, NSS moved to an office in a church. Technical support was provided by the Institute and the local council on aging. Work study students served as the NSS staff.

The first discussions focused on the immediate problems of elderly residents in the neighborhood. An early objective was to secure chairs for older shoppers in local supermarkets. A cooperative developer installed benches in a new shopping center. This achievement, while limited, encouraged the group to move on to more complicated problems.

An important test of the group came when an elderly woman with a wide range of problems asked for assistance. She had cats overrunning her house, boarders who would not pay their rent, property taxes overdue, and a long list of medical complaints. The NSS chairperson and a work study student made several visits to the widow to assist her in reducing her many problems. For example, they sought and received a tax rebate and thus helped her pay off the delinquent taxes. They asked another neighborhood group to assist in painting and repairing her house. The elderly woman gradually began to take control of her life. Her enthusiasm for living returned.

In 1975, its first full year of operation, NSS raised money largely from its membership. The expenses over the first eight months amounted to less than $40. A policy was developed to raise funds on a project-by-project basis. The overhead would be kept as low as possible. If necessary, the organization would return to meeting again around the kitchen table in its efforts to keep a low overhead.

The Ann Arbor City Council, recognizing the progress made by the group, awarded NSS a $2,000 grant for 1976 from the city's Community Development Revenue Sharing Fund. This grant was to pay for work study students, telephone service and mailings.

Through the mailings, NSS informed residents of services such as an arthritis screening program and a legal service program. Neighbors were encouraged to call the NSS office to volunteer or to seek assistance. Gradually, an increasing number of calls began to come in from elderly residents, friends of the elderly, and even from service agencies.

In 1976, a close collaboration was established with the Visiting Nurses Association, and a nurse was assigned to the neighborhood. She visited the homes of elderly residents accompanied by members of NSS. She made assessments of the elderly person's health care needs, while NSS

members attended to the individual's needs for social supports. The number of elder persons reached by NSS workers began to increase.

After inviting NSS to resumbit for another year of funding, the City altered the budget to offer a larger amount if NSS would increase its services. The final budget for the second grant year was $20,000 or ten times the first year grant.

The increase in funds enabled NSS to hire its chairperson as part-time executive director. By 1977, its third year, NSS had expanded its activities to cover over 100 elderly residents. While many of these could be served by a single visit or referral, there were several elderly people with multiple problems. In these cases, the NSS worker would provide the initial contact with the elderly neighbor. A referral would be made to the appropriate agency and neighbors were to be recruited to provide social supports, if needed. The NSS worker keeps a record of the problems encountered and the solutions sought.

As a result of the members' work, NSS was granted additional funds to do outreach through the area agency on aging. This was expected to lead to the development of NSS branches in other neighborhoods within the city. NSS would provide some central service and technical advice to these neighborhood branches.

A member of NSS who lived in public housing suggested that a cooperative unit for the elderly be developed in the neighborhood. A group of undergraduate students undertook a feasibility study and prepared a report. Support was gained from the student cooperative housing council, and a committee of residents in the neighborhood was established. In a related way, NSS has become involved in physical planning aspects within the neighborhood. Examination of the conditions of the streets, the location

of neighborhood shops, and the efficiency of the bus service are some examples of NSS's involvement in the physical aspects of the neighborhood.

NSS's success in serving the elderly is reflected in the increased number of persons contacting the office. The number has grown from a very few to over a hundred. The staff and volunteers are becoming more expert at directing formal services to the homebound and impaired elderly. Careful records are kept on the needs of individuals in the neighborhood. In this manner, NSS is able to advise service agencies on acceptable approaches, assist them in reaching out into the neighborhood, and if necessary, inform them of their deficiencies. The recommendations of the group have been sought by both service agencies and city planners. At this writing, NSS provides a basis for identifying and providing supports to elderly in the neighborhood. Through the use of volunteers and through an effort to return value for dollar received, NSS serves as a model for neighborhood-based approaches to supplement the formal care giving system. It is an exercise in shared concern.

Conclusion

KNOWLEDGE AND PLANNING

In this concluding chapter, we will stress the relationships of gerontologic knowledge to planning at the community and service levels.

As both Volumes I and II have stressed, knowledge about what older people are like and knowledge about their reactions to health, psychosocial and other forms of intervention are critical to planning for services and the coordination of services. This information is also a crucial aspect for the continuing reevaluation of basic plans and the administration of services. We all recognize the contradictions implicit in developing an efficient system of services that satisfies criteria of budgeting but does not do the job of promoting independent living for the elderly. Such contradictions are sometimes camouflaged by non-gerontologic priorities. For example, when programs are cut back, the provision of services based on stereotypic needs may substitute for an adequate system of providing a variety of options for people to meet their individual needs.

Those engaged in research relating to the many topics reported in these two volumes have the responsibility of reporting the results of their research despite personal feelings about the data or the fact that the data does not support the existence of particular programs. Without the candor of honesty, the stated goals of providing programs which will aid the elderly will be mere shibboleths. It is important that we recognize honestly and directly that management structure should not control research nor stultify the development of new knowledge. There is always need for research relevant to managerial problems as well as the need for academic research. Such research may possibly yield information "who's time is yet to come." Good management will always devote money and effort to developing new knowledge so as to be responsive to public needs. For example, there are many questions

that relate to the assessment of programs: Are they serving the target population as planned? How well? Are there desirable and undesirable consequences? Was the original plan feasible? These are all fertile areas for research.

We must keep in mind research in areas other than in gerontology. Research which produces a cure for cancers and/or prevents cardiovascular disease, if and when achieved, will have an enormous impact on planners and practitioners in the field of aging. These cures would alter the size and type of the older population, its service needs, and its social and financial resources. Such biomedical advances will produce, as well as eliminate, problems. The aging-field planner and practitioner should be aware of the various areas of ongoing and potential research. Such research must also be assessed by the planner: How solid are the data? Are there conflicting data? What reservations are there about the findings? What additional studies are needed before investing in a course of action?

Some of these issues are illustrated by an article in the January, 1978, issue of the Journal of Gerontology, called "Impact of Age Integration of the Well-Being of elderly Tenants in Public Housing." In an abstract of the article, J. D. Teaff et al report that age segregation showed small but reliable relationships to on-site activity participation, morale, housing satisfaction and neighborhood mobility. This study suggests that there are a number of favorable conditions associated with age-segregated living in public housing. Another study noted that most elderly persons did not prefer age-segregated housing. In both studies, people had reservations about close contacts with young people.

ON PLANNING A PLAN

An effective plan should (a) set forth goals concerning the desired quality of life for the elderly, (b) outline specific program objectives, and (c) define goals and objectives in precise, measurable terms such that progress may be evaluated.

One form of plan ranks goals according to priority based on the medical, social, and life-enrichment needs of the elderly. Program objectives under each goal are also ranked according to expected effectiveness and feasibility. These rankings make it possible to phase programs in accordance with budgeting.

ILLUSTRATIONS OF PRIORITY GOALS AND OBJECTIVES

Some examples of priority goals and specific objectives affecting older people are listed below to demonstrate how a plan puts knowledge about aging into useable form. This is an illustrative, not comprehensive, list.

Purpose	Goal	Objectives
Health promotion and protection	-- Provide local services to improve the behavior, health and security of older people.	-- A local, coordinated county or multi-county system for older-person-information-and-referral services.
	-- Decrease detrimental environmental action.	-- Patient education--on accidents, cancer, diabetes, heart disease, stroke, hypertension, learning and memory, nutrition, and other topics--by hospital rehabilitation, ambulatory care, and long-term care facilities.
	--Assure proper nutrition.	--Congregate and home-delivered meal programs serving a percentage of elderly.
Prevention services	-- Promote optimal physical and mental well-being by identifying disease or ill health at the presymptomatic stage.	-- Screening programs--for cancer, glaucoma, diabetes, heart disease, hypertension, stroke--accessible to all older people.
		-- Therapeutic programs to prevent suicides by older people.

	-- Protect against the development of detected disease.	-- Follow-up program to control development of disease.
Treatment services	-- Diagnose disease. Treat specific diseases and/or their symptoms.	-- 24-hour primary care available to older people. Coordination to assure continuity of care among levels or care. -- Sufficient hospital and long-term-care services.
Rehabilitation services	-- Assist the ill or disabled older person to maximize capacities.	-- Coordinate use of the mental and physical therapies. -- Provide therapies within congregate centers and apartments.
Maintenance services	-- Assistance in activities of daily living. -- Provide services to prevent or minimize deterioration of older people with chronic mental and/or physical conditions.	Homemaker health services available to all older people. -- Day-care services available to all older people. -- Transportation to maintain usual mobility and to facilitate use of services.

Enabling services	-- Provide enrichment programs for older people within schools and congregate residences. -- Assure accessible opportunities for creative group and interpersonal relations.	-- Variable creative educational opportunities by schools, within senior centers, for aged and retirement complexes. -- Designed opportunities for older people to participate in college courses. -- Indoor and outdoor recreational resources and their refinements, including appropriately structured camping. -- Group participation and enhancement of leadership and volunteer potential.

SPECIFIC POPULATIONS AND PLANNING

The United States is a country of people with diverse cultural, racial, and religious backgrounds. The constraints of being black, Mexican-American, Indian or members of another officially-recognized minority affects how older people see their medical and social needs and how they adapt to aging. For example, according to Harris polls, elderly white Americans have a more positive view of aging compared to elderly black Americans, who in turn, have a more positive view of aging than elderly Mexican-Americans. The elderly nonwhite person is likely to be worse off than the older white person in education, finances, health and longevity, notwithstanding special efforts in recent years.

One should keep in mind that ethnic background is just one clustering of the sociocultural influences which affect an individual. For the purposes of interpreting diversity, groupings of people based on social class or demography may be as useful. Moreover, the variation within any group is often as great as the average variation between groups.

To illustrate further the planning implications, consider that most older people prefer to retain their own independent households and to maintain relationships with relatives. Very few families (3%) with an older person as a head of the household also include grandchildren; only 3.3% of all older household heads have dependent children under age 18 residing with them. But for older people of Spanish-surnames, the percentage is not 3.3 but 10. Obviously, sociocultural factors--such as tradition, late marriage, economics, adequate housing or a combination of such factors--set this group apart from the elderly population as a

whole. Therefore, planning and subsequent delivery of services for members of this ethnic group have to be based on such knowledge about them.

Planning also must consider other demographic characteristics. For example, older widowers are six times more likely to remarry than are older widows. This is due to such factors as the much greater number of older women, and the fact that our culture more readily accepts marriage between an older man and a younger woman than the reverse. There is a higher remarriage rate among the nonwhite elderly than among the white elderly.

Planning areas especially affected by some ethnic and demographic factors:

Areas	Points to Consider
Housing units	Numbers of one bedroom and two bedroom units.
Home service	Need for meals-on-wheels; other outside personal services are often reduced when there is a couple.
Transportation	A couple increases the possibility of being able to have adequate transport or of using what is available.
Nursing home beds	With couples, there is less need for long-term-care beds, within limits set by individual disability.
Enrichment and trade programs	Motivation and mobility for some older people to participate in personal enrichment programs are enhanced by a spouse.
	The need for home-repair courses may be reduced since the older man usually carries this knowledge.

Another illustration useful to the planner is provided by the table below on the gross disparity in finances by age and race. It shows that: 1) older people do not fare as well as the population as a whole; 2) in general, older people are somewhat better off now than before; 3) older nonwhites are much worse off than older whites; and 4) the improvement in financial status by older nonwhites is at a lesser pace than for older whites.

Percentage of persons below the low-income level, by age and race for 1971, 1973, and 1976

	1971	1973	1976
All persons			
Total	12.5%	11.1%	11.8%
65 years and over	21.6%	16.3%	15.0%
White			
Total	9.9%	8.4%	9.1%
65 years and over	19.9%	14.4%	13.2%
Black			
Total	32.5%	31.4%	31.1%
65 years and over	39.3%	37.1%	34.8%
Black and other minorities			
Total	30.9%	29.6%	29.4%
65 years and over	38.4%	35.5%	32.7%

The declining ratio of older men to older women is a modern phenomenon with planning implications. It is expected to accelerate. By the end of this century, a ratio of two elderly women per elderly man may well be realized.

For older women as well as men, age-related losses can change the sexual and other roles they play. The accelerating increase in the surplus of elderly women suggests that age-related losses will have a much more substantial effect on older women than on older men. Losses are not absolute for all older people; some individuals may suffer small losses in various categories, given below:

Type	Loss
Social	-- Family, friend, job, social status
Physical	-- Health, strength, appearance
Psychological and cognitive	-- Change in self-esteem, rote memory, creativity, conditionability, senses, speed and timing

(Source: Butler, R. N. & Lewis, M. I. Aging and Mental Health: Positive Psychological Approaches. St. Louis: C. V. Mosby, 1977.)

Older widows have a low remarriage rate and may require special services to facilitate their adaptation in old age. For example, they may need encouragement and assistance in making lifestyle changes. Their tendency to isolation may require the tailoring of health care programs with special focus placed on prevention of depression and on periodic checkups. Many women lose their source of emotional support when their children become adults and move out of the family household. Other lose their status and social function when they become widows. The development of services and programs that offer opportunities for the maintenance of status and social function are of great value for women who could benefit from them.

EPILOGUE

It would be a gross miscarriage of the function of these volumes on working with older people--and specifically of the responsibilities we assign to planners and practitioners--to conclude without a special emphasis:

The older person, as the consumer or recipient of services, deserves a role in making policy for the systems that serve him or her. Providing for such a role is entirely in harmony with the goal of maximizing the older person's potentials for independent living.

For the elderly to contribute to decisionmaking, they must have access to information. The dissemination of information through open meetings and publications--in language that is understandable and practical--is critical to their participation. The elderly should have access to studies of the effects of plans and services for them. Discussion among themselves and with planners and practitioners can be facilitated by such means as a citizens advisory committee.

An offshoot of a participatory process within the field of aging services is to equip citizens to speak about their needs in general. Older people are not a passive population. Many lack only the opportunity to demonstrate to themselves and others that they have the voice, brain, and muscle to contribute to the well-being of our society.

Appendix: Some Resources for Further Information

Appendix A: Bibliography

HUMAN SERVICES

Aging Programs: A Report on Services to the Elderly.

No. 1. Transportation, 1971

No. 2. Housing, 1971

No. 3. Health, 1977

No. 4. Organization, 1977

No. 5. Security, 1977

No. 6. Cooperation: A Two County Office on Aging, 1978

Washington, D. C.: National Association of Counties Research Foundation.

Beattie, Walter M. Aging and the Social Services. In Binstock, R. H. & Shanas, E. (Eds.), Handbook of Aging and the Social Sciences. New York: Van Nostrand Reinhold Co., 1976.

A review of current social service programs for the aging, including other topics such as ideological constraints on the development of services to the aging and models of social service systems.

Bell, D., Kasschau, P., & Zellman, G. Delivering Services to Elderly Members of Minority Groups: A Critical Review of the Literature. Santa Monica, CA: Rand, 1976.

Includes: service delivery with respect to immigration histories, demographic and social characteristics, and barriers to service use for Asian and Pacific Americans, Mexican Americans, Native Americans, and Black elderly.

Bild, B. R., & Havighurst, R. J. Senior Citizens in Great Cities: The Case of Chicago. The Gerontologist, 1976, 16, 1-88.

A survey of attitudes, concerns and wage of services among seven different groups of elderly in metropolitan Chicago, including blacks, ethnics, elderly living in residential hotels and in public housing.

Feifel, Herman. New Meaning of Death. New York: McGraw-Hill Book Co., 1977.

Includes: information related to death from the perspectives of clinical findings and strategies pertinent for professional practice, existing conceptual frameworks, and public policy.

Final Report of Services to Impaired Aged, Pilot Program. Chicago, IL: Council for Community Services, 1975.

Includes: profile of clients and services, description of project services, cost, study of client sample, and definitions of services and service units.

Hardy, R. E., & Cull, J. G. Organization and Administration of Service Programs for the Older American. Springfield, IL: Charles C. Thomas, 1975.

Includes: a description and bibliography for aging service programs, aspects of counseling (problems of the aging worker, family service center, senior citizen programs and centers for selected states), nursing home care.

International Federation on Aging. Home Help Services for the Aging Around the World. Washington, D. C.: International Federation on Aging, 1975.

Includes: services in western European countries, Great Britain, Netherlands and some of the developing countries.

Journal of Architectural Education, Volume XXXI, Number 1. Washington, D. C.: Association of Collegiate Schools of Architecture, Inc., 1977.

This entire issue is entitled "Environments and Aging." It includes discussions on "An Ecological Theory of Aging Applied to Elderly Housing" and "Designing Housing Environments for the Elderly" as well as several teaching case studies.

Kahn, A. J. Social Policy and Social Services. New York: Random House, 1973.

An analysis of the role and meaning of social policy and services in contemporary America.

Kubler-Ross, E. Death: The Final Stage of Growth. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1975.

Includes: discussion of the realities of death and dying from the perspectives of various practitioners who work with dying and death.

Lawton, M. P., & Byerts, T. O. (Eds.). Community Planning for the Elderly. Washington, D. C.: Gerontological Society, 1973.

Includes: information on the older person and the aging process, community planning, types of services and planning new services, and planning for the aged in new communities.

Lawton, M. P., Newcomer, R. J., & Byerts, T. O. Community Planning: Designing Services and Facilities. Stroudsburg, PA: Dowden, Hutchinson and Ross, Inc., 1976.

Includes: the aged population in a community setting, planning and policy decisions as they affect the elderly, programmatic aspects of housing and community services.

National Council of Jewish Women. Continuing Choices: A Comprehensive Handbook of Programs for Work with Older Adults. New York: National Council of Jewish Women, 1975.

Includes: an extensive list of services and programs for the older adult; the objective, services, clients served, time commitment, and source of funding is given for each program.

National Council on the Aging. Myth and Reality of Aging in America. Washington, D. C.: National Council on the Aging, 1974.

Report of a survey of a national sample of the elderly encompassing responses to a wide array of questions regarding attitudes and interests.

Neugarten, B. L. Age Groups in American Society and the Rise of the Young-Old. The Annals of the American Academy of Political and Social Science, 1974, 415, 187-198.

Discussion on planning programs for a definable cohort of young-old and examination of the implication of this cohort for services.

Rosenberg, M., & Brody, R. Systems Serving People: A Title XX Planning Resource. Cleveland, OH: Case Western Reserve University, 1974.

Includes: An analysis of the social service system with respect to new approaches, research design, overview of existing systems, the access to subsystems, service delivery subsystems, administrative subsystems, and state and local relationships.

Steven, Z. (Ed.). Readings in Aging and Death: Contemporary Perspective. New York: Harper & Row, 1977.

Includes: discussions on losses, widowhood, dying, death and grief as part of the aging process.

Tobin, S. S. Old People. In Maas, H. S. (Ed.), Research in the Social Services: A Five Year Review, Volume III. New York: National Association of Social Workers, 1978.

A recent review of the research on social services including programs for the less vulnerable and the institutionalized elderly.

Tobin, S. S., Davidson, S. M., & Sack, A. Effective Social Services for Older Americans. Ann Arbor: Institute of Gerontology, 1976.

A series of dilemmas that confront planners of social services for the elderly are considered. For each of the nine dilemmas the pros and cons of one or another resolution are discussed. Preferred resolutions are then suggested.

Tobin, S. S., & Leiberman, M. A. Last Home for the Aged: Critical Implications of Institutionalization. San Francisco: Jossy-Bass, 1976.

A longitudinal study of older people becoming institutionalized. Examines the effects of the process on psychological states and functional well-being. Implications for social health services are discussed.

U. S. Congress, House Select Committee on Aging. Federal Responsibility to the Elderly. (Executive Programs and Legislative Jurisdiction.) Washington, D. C.: Government Printing Office, 1975.

Includes: charts depicting major federal programs benefiting the elderly by agency and category. (Employment, health care, housing, income maintenance, social service programs, training and research, and transportation.)

Vickery, F. D. Creative Programming for Older Adults: A Leadership Training Guide. New York: Association Press, 1972.

Includes: older Americans functioning in a technological age, effects of the aging process on social functioning, and development and administration of social programs for the older adult.

HUMAN SERVICES: HEALTH SERVICES

Adult Day Facilities for Treatment, Health Care and Related Services.

A working paper prepared for use by the Special Committee on Aging, U. S. Senate, 94th Congress, 2nd Session. Washington, D. C.: Government Printing Office, 1976.

Includes: adult day health centers, day hospitals, after-care, senior group programs, home health services, transportation, community network and cost.

Community Care Programs for the Frail Elderly. New York: Community Service Society of New York, 1975.

Includes: problems and priorities in community mental health services, community services and needs, and a summary of care programs in New York. In the summary a profile and description are given for each program listed under the following subject categories: Geriatric Community Programs with Mental Health Funding, Home Care Programs, Day Care Programs, and Other Community Service Programs.

Davis, R. H. (Ed.). Health Services and the Mexican-American Elderly: A Monograph from the Ethel Percy Andrus Gerontology Center. Los Angeles, CA: University of Southern California Press, 1973.

Includes: Medical social work, physical health, mental health and community resources.

Hassinger, E. W., & Whiting, L. R. (Eds.). Rural Health Services: Organization, Delivery and Use. Ames, Iowa: Iowa State University Press, 1976.

Includes: benefits under Medicare and Social Security, access to health care, community health care systems, communication systems, Tufts-Delta health project, utilization of health services.

Padula, H. Developing Day Care for Older People: A Technical Assistance Monograph. Prepared for the Office of Economic Opportunity. Washington, D. C.: National Council on the Aging, 1972.

Includes: following topics related to day care: history, definition, target population, program, transportation, size, hours, physical standards, staffing, records, and planning.

Strokes, M., & Edgerton, J. Development of Home Health Services in Selected Communities: Changing Patterns in the Provision and Utilization of Health Services for the Aged (Medicare). Kansas City, MO: Institute for Community Studies, 1970.

Includes: description of communities and development of services.

Task Force on the Future of Long-Term Care in the United States. The Future of Long-Term Care in the United States: The Report of the Task Force. Springfield, VA: Department of Commerce, National Technical Information Service, 1977.

Includes: concepts, scope and elements of long-term care with potential resources and services; principles for planning and programming.

Trager, B. Homemaker Services for the Aged and Chronically Ill. In Readings in Homemaker Service: Selected Papers Presenting Background, Uses and Practices of Homemaker-Home Health Aide Programs. New York:

National Council for Homemaker Services, 1969.
Includes: information on planning, cost, staff recruitment, and observation techniques.

U. S. Senate. Special Committee on Aging. Home Health Services in the United States: A Working Paper on the Current Status. Prepared by the Special Committee on Aging, U. S. Senate, 93rd Congress, 1st Session. Washington, D. C.: Government Printing Office, 1973.
Includes: Status report and recommendations and a summary from a conference, "In-Home Services: Toward a National Policy," held in Columbia, Maryland, June 1972.

HUMAN SERVICES: PROTECTIVE SERVICES

Alexander, G. J., & Lewin, T. H. D. The Aged and the Need for Surrogate Management. Syracuse, NY: Syracuse University, 1972.
Includes: determination of incompetency, procedure for the surrogate management of property, estate management and the incompetent, restoration to competence, and summary of model state statutes.

Blenkner, M. Protective Services for Older People: Findings from the Benjamin Rose Institute Study. Social Casework, 1971, 52, 483-522.
Includes: a report on a research demonstration project of protective services and protective practice in serving the mentally impaired elderly.

Hall, G. H., & Mathiasen, G. (Eds.). Guide to Development of Protective Services for Older People. Springfield, IL: Charles C. Thomas, 1973.

Includes: protection for elderly persons in the community, organizing service projects, a list of demonstration communities, service clients, service programs, and implications for further development.

Horowitz, G., & Estes, C. Protective Services for the Aged. U. S. Administration on Aging. Washington, D. C.: Government Printing Office, 1971.

Includes: description of a program, the clients, and an experimental study.

Legal Council for the Elderly: A Manual on Public Benefit Programs. Washington, D. C.: American Association for Retired People--National Retired Teachers Association, 1976.

Manual of Funding Sources and Models for Delivering Legal Services to the Elderly. Los Angeles, CA: The National Senior Citizens Law Center, 1976.

Mathiasen, G. (Ed.). Guardianship and Protective Services for Older People. New York: National Council on the Aging, 1963.

Includes: Scope and nature of need for guardianship and protective services, fiduciary relationships, assistance with financial management, care and supervision, and the law as a base for care and supervision.

Overcoming Barriers to Protective Services for the Aged: Report of a National Institute on Protective Services. Prepared and edited by Gertrude Hall and Geneva Mathiasen. New York: National Council on the Aging, 1968.

Includes: a framework for action, identifying and overcoming barriers to actions, definition of protective service, coordination of interdisciplinary communication and cooperation, function of the protective service advisory committee, and some case studies.

Schaupp, D. L. Consumer Handbook for Senior Citizens. Business and Economic Studies, Volume 13, no. 1. Morgantown, WV: Bureau of Business Research, West Virginia University, 1975.

Includes: services available to seniors; how to complain and get results; facts about fraud, crime and burglaries; credit and money management; housing, insurance, funerals, legal advice, tax information, social security, medicare, medicaid, buying drugs, employment and welfare. (For the senior citizen.)

U. S. Department of Health, Education, and Welfare. Social and Rehabilitation Service. Community Services Administration. Report of the National Protective Services Project for Older Adults. Washington, D.C.: Government Printing Office, 1971.

Includes: project plan, programs in operation, services to clients, evaluation of the program, cost of services and implications for states.

Waddell, F. E. The Elderly Consumer. Columbus, MD: Human Ecology Center, Antioch College, 1976.

Includes: demographics of elderly consumers, income and expenditures, elderly consumers and retirement, elderly consumer market, consumer problems of the elderly, decision making of elderly consumers, implications for program development, abstracts of related doctoral and masters theses and selected references on the elderly consumer.

Wasser, E. Protective Casework Practice with Older People: An Explication of the Service Component in the Benjamin Rose Institute Study. Cleveland, OH: The Benjamin Rose Institute, 1974.

Includes: Background and development of protective services, casework practice in the project, ancillary services, perspective, illustrative case analysis and bibliography.

TRAINING RESOURCES

Deichman, E. S., & O'Kane, C. P. Working with the Elderly: A Training Manual. Buffalo, NY: D.O.K. Publishers, 1975.

Ernst, M., & Shore, H. Sensitizing People to the Processes of Aging: The Inservice Educator's Guide. Denton, TX: North Texas State University, Center for Studies in Aging, 1975.

Lowy, L. Training Manual for Human Service Technicians Working with Older People. (Parts I and II.) Boston, MA: Boston University Bookstore, 1968.

Part I for trainers, Part II for trainees.

Steenberg, C. V., & Karasik, R. Keyword Index to Training Resources in Aging. Durham, NC: Center for the Study of Aging and Human Development, Duke University Medical Center, 1977.

FILMS RELATED TO AGING

About Aging: A Catalogue of Films. Los Angeles, CA: Ethel Percy Andrus Gerontology Center, University of Southern California, 1977.

Sahara, P. in cooperation with The University of Michigan Audio Visual Education Center. Media Resources for Gerontology. Ann Arbor, MI: The University of Michigan Press, 1977.

Appendix B: A Guide to Reference Sources in Gerontology

This guide was developed by Scripps Foundation Gerontology Center, Miami University, Oxford, Ohio in 1977. The reference sources included are:

basic handbooks in gerontology,

periodicals,

newsletters,

indexes and abstracts useful in gerontology,

directories,

government publications,

textbooks and readings, and

bibliographies.

Copies of the guide may be obtained from Scripps Foundation Gerontology Center ($1.00 per copy). The lists of directories and government publications are reproduced in this section.

Directories

Cohen, L., & Oppedisano-Reich, M. A National Guide to Government and Foundation Funding Sources in the Field of Aging. Garden City, NY: Adelphi University Press, 1977.

Detailed information by foundation and agency.

International Federation on Ageing. Survey of Periodicals in Social Gerontology and Geriatrics. Washington, D. C.: International Federation on Ageing, 1976.

Musson, Noverre. The National Directory of Retirement Resources. New York: Frederick Fell, 1973.

National Council on the Aging. A National Directory of Housing for Older People. New York: National Council on the Aging, 1969.

Includes a guide for selection.

National Council on the Aging. Directory: National Organizations with Programs in the Field of Aging. Washington, D. C.: National Council on the Aging, 1971.

Voluntary organizations.

National Institute of Senior Centers. Directory of Senior Centers and Clubs: A National Resource. Washington, D. C.: National Council on the Aging, 1974.

United Nations. International Directory of Organizations Concerned with the Aging. New York: Department of Economic and Social Affairs, 1977.

United States Department of Health, Education and Welfare; Administration on Aging. Directory: Project Summaries and Addresses (April, 1976). Washington, D. C.: Government Printing Office (HE 1.213:M72), 1976.

Model Projects on Aging Program, Title III of Older Americans Act.

United States Department of Health, Education and Welfare; Administration on Aging. Home Delivered Meals: A National Directory. Washington, D. C.: Government Printing Office (HE 17.302: M46), 1971.
Computer print-out of 350 programs by state.

United States Department of Health, Education, and Welfare; Administration on Aging. Inventory of Federal Statistical Programs on the Elderly. Washington, D. C.: Interdepartmental Working Group on Aging, National Clearinghouse on Aging, in progress.

United States Department of Health, Education, and Welfare; Administration on Aging. National Directory of Educational Programs in Gerontology. Washington, D. C.: Government Printing Office, 1976.
Prepared by the Association for Gerontology in Higher Education to provide information on the nature and location of gerontological programs. Listed by state and educational institution.

United States Department of Health, Education, and Welfare; National Center for Health Statistics. Directory of Nursing Home Facilities. Rockville, MD: Government Printing Office (HE 20.6202:N93W), 1975.
Four volumes by geographic area: Northeast, North Central, South, and West.

United States Department of Health, Education, and Welfare; National Center for Health Statistics. Nursing Homes: A County and Metropolitan Area Data Book. Rockville, MD: Government Printing Office (HE 20.2202:C83/Sec. 2/969), 1973.
Data from the 1969 Master Facility Inventory.

United States Department of Health, Education, and Welfare; Social Security Administration. Directory: Medicare/Medicaid Providers and Suppliers of Services. Washington, D. C.: Government Printing Office (HE 3.51/5:975), 1975.

By state and category of care facility.

United States Department of Health, Education and Welfare; Social Security Administration. Social Security Programs Throughout the World. Washington, D. C.: Government Printing Office (HE 3.49:48), 1976.

Benefits by country.

United States Senate. Special Committee on Aging. Senior Opportunities and Services Director of Programs. Washington, D. C.: Government Printing Office (Y4.Ag4:DP5), 1975.

Senate continuation of former OEO directory.

Government Publications

United States Department of Commerce; Bureau of the Census. Demographic Aspects of Aging and the Older Population in the United States. Washington, D. C.: Government Printing Office (Series P-23, #59, c3.186:P-23/59), 1976.

Includes geographic distribution, mortality, and social and economic characteristics.

United States Department of Commerce; Bureau of the Census. Statistical Abstract of the United States. Washington, D. C.: Government Printing Office (c3.134:976), 1976.

Annual national data book.

United States Department of Health, Education, and Welfare; Administration on Aging. A Comprehensive Inventory of Federally Supported Research in Aging, 1966-1975. Washington, D. C.: Government Printing Office, 1976.

Ten volumes, prepared for the Interdepartmental Task Force on Research in Aging.

United States Department of Health, Education, and Welfare; Administration on Aging. Current and Potential Areas of Federal Support and Interest in Aging Research. Washington, D. C.: Government Printing Office (HE 1.202:F31), 1976.

United States Department of Health, Education, and Welfare; Administration on Aging. Older Americans Act of 1965, as Amended. Washington, D. C.: Government Printing Office (HE 1.205:ol 1/976), 1976.

The Older Americans Act of 1965 and related acts.

United States Department of Health, Education, and Welfare; Administration on Aging. Strategy for Development of the National Clearing House on Aging. Appendix B: A Handbook of Information Resources in the Field of Aging. Washington, D. C.: Government Printing Office, 1975.

United States Department of Health, Education, and Welfare; National Center for Health Statistics. Health in the Later Years of Life. Rockville, MD: Government Printing Office (HE 20.2202:L34), 1971. Chartbook design.

United States Department of Health, Education, and Welfare; Social Security Administration. Demographic and Economic Characteristics of the Aged. Washington, D. C.: Government Printing Office (HE 3.49:45), 1975.

Based on a 1968 Social Security Survey.

United States Department of Health, Education, and Welfare; Social Security Administration. Social Security Handbook. Washington, D. C.: Government Printing Office (HE 3.6/2:SO 1/3), 1974.

Basic information on Social Security including retirement, survivors, disability and health insurance, black lung benefits and supplemental security income.

United States Department of Health, Education, and Welfare; Social Security Administration. Your Medicare Handbook. Washington, D. C.: Government Printing Office (HE 3.6/3:M46/4/977), 1977.

Description of Medicare benefits and how to get them, written for recipients.

United States House of Representatives; Select Committee on Aging.

Numerous hearings and reports from 1975.

United States Senate; Special Committee on Aging.

Numerous hearings and reports from 1961.

White House Conference on Aging, 1971.

Reports on: The Aging and Aged Blacks, The Asian American Elderly, Disability and Rehabilitation, Education, Elderly Indian, Employment and Retirement, Facilities, Programs and Services, Government and Non-Government Organization, Health Care Strategies, Housing, Income, Nutrition, Physical and Mental Health, Planning, Protective and Social Support, Research and Demonstration, Retirement Roles and Activities, Roles for Old and Young, Rural and Poor Elderly, Spanish-Speaking Elderly, Spiritual Well-Being, Transportation.

Appendix C: Directory of Selected Organizations Involved in Aging

This directory has been adapted from Instructor's Manual to Accompany Social Problems of the Aging: Readings by Mildred M. Seltzer and Marilyn M. Wiles, copyrighted 1978 by Wadsworth Publishing Company, Inc., Belmont, California 94002. Our appreciation is extended to the authors and the publisher for permission to reproduce this material.

ACTION

806 Connecticut Ave., N.W., Washington, D. C. 20525

The federal volunteer agency which administers the Peace Corps, VISTA, SCORE, Foster Grandparent Program, and RSVP.

Periodical: Interaction.

ACTION FOR INDEPENDENT MATURITY (AIM)

1909 K St., N. W., Washington, D. C. 20006

A division of AARP which helps people between 50 and 65 plan their retirement.

Periodical: Dynamic Maturity (Monthly).

ADMINISTRATION ON AGING

Office of Human Development, US Department of HEW,

330 Independence Ave., S. W., Washington, D. C. 20201

Administers the Older Americans Act.

Periodical: Aging.

AGING RESEARCH INSTITUTE

342 Madison Ave., New York, NY 10017

Encourages, supports and performs research studies on physiological

aspects of the aging processes and the prevention, diagnosis, and treatment of diseases most common among the aged.

AMERICAN AGING ASSOCIATION

c/o Denham Harman, M.D., University of Nebraska, College of Medicine, Omaha, NE 68105

Promotes biomedical aging studies directed toward slowing down the aging process, informs the public of the progress of aging research, and spreads knowledge of gerontology among physicians and other health workers.

Periodical: Age.

AMERICAN ASSOCIATION OF HOMES FOR THE AGING

1050 17th St., N. W., Suite 770, Washington DC 20036

Develops curricula for administrators of homes and conducts institutes and workshops.

Periodicals: Washington Report (biweekly); Concern (bimonthly).

AMERICAN ASSOCIATION OF RETIRED PERSONS

1909 K St., N. W., Washington, DC 20049

Membership open to any person 55 years of age or older. Offers health, life, and auto insurance, group travel service, and sponsors community service programs.

Periodicals: News Bulletin (monthly); Modern Maturity (bimonthly).

AMERICAN COLLEGE OF NURSING HOME ADMINISTRATORS

4650 East-West Hwy., Washington, DC 20014

A membership organization; publishes reports on the nursing home industry.

AMERICAN GERIATRICS SOCIETY

10 Columbus Circle, New York, NY 10019

Promotes educational research in aging and clinical geriatrics.

Periodicals: Journal of the American Geriatrics Society (monthly); Newsletter (monthly).

AMERICAN HEALTH CARE ASSOCIATION

1200 15th St., N. W., Washington, DC 20005

A federation of state associations of nursing homes. Conducts seminars and conferences as continuing education for nursing home administrators.

Periodicals: Weekly Notes; Modern Nursing Home (monthly); Journal of the American Health Care Association (quarterly).

AMERICAN MEDICAL ASSOCIATION, COMMITTEE ON AGING

535 North Dearborn St., Chicago, IL 60610

Works on policies concerning the medical, nursing, and other health services in long-term care facilities.

THE AMERICAN SOCIETY FOR GERIATRIC DENTISTRY

431 Oakdale Ave., 913, Chicago, IL 60657

Promotes postgraduate education in gerontology and geriatrics for the dental practitioner.

Periodicals: The Journal of the American Society for Geriatric Dentistry (quarterly).

ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION

c/o Gerontological Society, 1835 K St., N. W.

Washington, DC 20006

An institutional membership organization providing a network of communication among educational institutions which provide professional education and training, research, and technical assistance in the field of gerontology. Publishes a quarterly newsletter and annual proceedings.

ASSOCIATION FOR THE ADVANCEMENT OF AGING RESEARCH

309 Hancock Building, University of Southern California,

Los Angeles, CA 90007

Organizes and supports research efforts on the effects of aging on the quality of later life.

B'NAI B'RITH, SENIOR CITIZENS HOUSING COMMITTEE

1640 Rhode Island Ave., N. W., Washington, DC 20036

Offers housing for low-income senior citizens.

CENTRAL BUREAU FOR THE JEWISH AGED

225 Park Ave. S., New York, NY 10003

Serves as coordinating group for the New York Metropolitan Jewish community to study the problem of providing effective care for the aged.

Periodical: Aspects of Aging.

CHURCH OF THE BRETHREN HOMES AND HOSPITALS ASSOCIATION

c/o Morrison's Cove Home, Martinsburg, PA 16662

For the administrators and board members of the Brethren Homes for the Aged and one hospital.

CITIZENS FOR BETTER CARE IN NURSING HOMES, HOMES FOR THE AGED AND OTHER AFTER-CARE FACILITIES

960 E. Jefferson Ave., Detroit, MI 48207

Seeks to improve the quality of care in nursing homes and homes for the aged and investigates issues affecting the health of the elderly.

Periodical: Annual Report.

CONCERNED SENIORS FOR BETTER GOVERNMENT

1346 Connecticut Ave., N. W., Rm. 1213, Washington, DC 20036

Membership of AFL-CIO retirees; the purpose is political education and voter registration.

CONGRESS OF SENIOR CITIZENS ORGANIZATIONS OF FLORIDA

127 N.E. First Ave., Miami, FL 33132

A state-wide organization to coordinate senior citizens organizations.

DIVISION OF ADULT DEVELOPMENT AND AGING (DIVISION 20), AMERICAN PSYCHOLOGICAL ASSOCIATION

1200 17th St., N. W., Washington, DC 20036

Division 20 is the arm which coordinates the APA's activities concerning the older person.

FEDERAL COUNCIL ON THE AGING

Dept. of HEW, Rm. 4260, HEW North

330 Independence Ave., S. W., Washington, DC 20201

The citizens advisory body established by the Older Americans Act to advise and assist on federal policies regarding the aging.

FLYING SENIOR CITIZENS OF USA

96 Tamarack St., Buffalo, NY 14220

Affiliated with the National Council of Senior Citizens; aims to petition for reduced air fares for senior citizens on domestic airlines.

Periodical: News Letter (monthly).

THE GERONTOLOGICAL SOCIETY

1835 K St., N. W., Washington, DC 20006

Membership organization of the professionals in the field of aging; aims to promote the scientific study of aging, to stimulate communications among disciplines, to advance the development of public policy, and to set standards in gerontology.

Periodicals: The Gerontologist (bimonthly); The Journal of Gerontology (bimonthly).

GERONTOLOGY RESEARCH CENTER, NATIONAL INSTITUTE ON AGING

Baltimore City Hospitals, Baltimore, MD 21224

Conducts research on cellular and physiological me hanisms of aging and on the behavioral changes of aging.

GOLDEN RING COUNCILS OF SENIOR CITIZENS CLUBS

22 W. 38th St., New York, NY 10018

Promotes social activities in the clubs, better living conditions, and social action to change legislation.

Periodical: Senior Citizens Reporter (quarterly).

GRAY PANTHERS

3700 Chestnut St., Philadelphia, PA 19104

An organization of consciousness-raising activist group aiming to combat ageism. It maintains an information and referral service, and is developing curricula for transgenerational education.

Periodical: The Network (5/year).

INTERNATIONAL ASSOCIATION OF GERONTOLOGY

Section of Biological Ultrastructure, The Weigmann Institute of Science, P.O.B. 26, Rehorot, Israel

Organization of national societies of gerontology. Promotes research, training of professional personnel, and cooperation among its members.

Periodical: "IAG News" in The Gerontologist.

INTERNATIONAL CENTER FOR SOCIAL GERONTOLOGY

Suite 350, 425 13th St., N. W., Washington, DC 20004

Promotes communication and information exchange among gerontologists throughout the world.

INTERNATIONAL FEDERATION ON AGEING

1909 K St., N. W., Washington, DC 20006

Federation of national voluntary organizations that represent the elderly or provide services to them.

Periodical: Ageing International (quarterly).

INTERNATIONAL SENIOR CITIZENS ASSOCIATION

11753 Wilshire Blvd., Los Angeles, CA 90025

Provides international coordination to safeguard interests of senior citizens, and establishes communication among older citizens about educational and cultural developments.

Periodical: Newsletter (quarterly).

JEWISH ASSOCIATION FOR SERVICES FOR THE AGED

222 Park Ave. S., New York, NY 10003

Social welfare organization with the aim of keeping the older adult in the community and providing the services necessary to do so.

Periodicals: Newsletter; Progress Report (annual).

LEAGUE OF ELDERLY GENTLEMEN IN REDUCED CIRCUMSTANCES

1457 16th Ave., Honolulu, HI 96816

Affiliated with the Gray Panthers; aims to secure financial relief.

LEGAL RESEARCH AND SERVICE FOR THE ELDERLY

1511 K St., N. W., Washington, DC 20005

Specializes in legal problems of the elderly.

LEGAL SERVICE FOR THE ELDERLY POOR

2095 Broadway, New York, NY 10023

Organization of lawyers who advise the elderly on legal problems.

MASSACHUSETTS ASSOCIATIONS OF OLDER AMERICANS INC.

110 Arlington St., Boston, MA 02116

NATIONAL ALLIANCE OF SENIOR CITIZENS

Box 40031, Washington, DC 20016

Consists of regional groups which advocate sound fiscal policy and the American system of individuality and freedom.

NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

1828 L St., N. W., Washington, DC 20036

Coalition of area agencies on aging.

NATIONAL ASSOCIATION OF JEWISH HOMES FOR THE AGED

2525 Centerville Rd., Dallas, TX 75228

Coordinating organization for Jewish retirement and nursing homes, geriatric hospitals and other special facilities for the aged and chronically ill.

Periodicals: Progress Report (quarterly); Directory (biennial).

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

1533 New Hampshire Ave., N. W., Washington, DC 20036

Serves federal annuitants under the retirement laws and sponsors and supports legislation.

Periodicals: Retirement Life (monthly); Newsletter.

NATIONAL ASSOCIATION OF STATE RETIREMENT ADMINISTRATORS

c/o Employees' Retirement System of Alabama

64 N. Union St., Rm. 756, Montgomery, AL 36104

Members are administrators of state employee retirement systems.

NATIONAL ASSOCIATION OF STATE UNITS ON AGING

1828 L St., N. W., Washington, DC 20036

Provides coordination among state agencies on aging.

NATIONAL CAUCUS/CENTER ON THE BLACK AGED

1730 M St., N. W., Suite 811, Washington, DC 20036

Coordinates activities, conducts research, provides annuitant service,

trains personnel, and develops curricula. Main focus is on the problems of the Black Aged, especially in the areas of income, housing, and health services.

NATIONAL COMMITTEE ON ART EDUCATION FOR THE ELDERLY

Culver Stockton College, Canton, MO 63435

Promotes development in art education for the elderly and aims to expand the role of art education in our society.

Periodical: Exchange (semiannual).

NATIONAL CONFERENCE ON PUBLIC EMPLOYEE RETIREMENT SYSTEMS

275 E. Broad, Columbus, OH 43215

Aims to enhance the rights and benefits of employees in public retirement systems.

Periodicals: Word from Washington (monthly); Proceedings Record (annual).

NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES

67 Irving Place, New York, NY 10003

Provides education and a central source of information on homemaker-home health aide services.

NATIONAL COUNCIL OF HEALTH CARE SERVICES

1200 15th St., N. W., Washington, DC 20005

Membership organization of proprietary long-term care facilities.

NATIONAL COUNCIL OF SENIOR CITIZENS

1511 K St., N. W., Washington, DC 20005

Develops information for Congress, the general public, and its own

members on services for the elderly.

Periodical: Senior Citizens News (monthly).

NATIONAL COUNCIL ON BLACK AGING

P. O. Box 8522, Durham, NC 27707

Provides consultative services about developing projects for the elderly, research about aged persons, and conducts workshops focused largely upon ways of improving the delivery of services to minority persons.

Periodical: Black Aging.

NATIONAL COUNCIL ON TEACHER RETIREMENT

1390 Logan, Denver, CO 80203

Membership organization which performs research on retired teachers and teacher retirement systems.

NATIONAL COUNCIL ON THE AGING

1828 L St., N. W., Washington, DC 20036

Serves as a central resource providing information, materials and technical assistance to professionals and organizations in the field of aging.

Periodicals: Perspective on Aging (bimonthly); Current Literature on Aging (quarterly); Industrial Gerontology (quarterly); NISC Memo (monthly); National Institute of Industrial Gerontology Journal (quarterly).

NATIONAL GERIATRICS SOCIETY

212 W. Wisconsin Ave., Third Floor, Milwaukee, WI 53203

Promotes techniques of care for aged, infirm, chronically ill,

handicapped, and convalescent patients.

Periodical: Views and News (monthly).

NATIONAL INSTITUTE OF MENTAL HEALTH

NIMH Center on Aging, 5600 Fishers Lane, Rockville, MD 20052

Initiates and supports mental health programs concerning the aged.

NATIONAL INSTITUTE ON AGING

NIH, Bethesda, MD 20014

Supports and conducts biomedical, social and behavioral research and training related to the aging process.

NATIONAL INTERFAITH COALITION ON AGING

220 S. Hull St., Athens, GA 30601

Coordinates religious efforts in aging and provides direction to organized religious groups in responding to the recommendations of the 1971 White House Conference on Aging.

NATIONAL RETIRED TEACHERS ASSOCIATION

1909 K St., N. W., Washington, DC 20006

Membership organization serving all older persons

Periodicals: News Bulletin (monthly); NRTA Journal (bimonthly); Modern Maturity.

NATIONAL SENIOR CITIZENS LAW CENTER

1709 West 8th St., Los Angeles, CA 90017

Promotes research in legislation affecting the older American; has established a network of information on state laws, and acts as an advocate for the senior citizen.

Periodical: Legislative Newsletter (weekly) from Washington Office: 1200 15th St., N. W., Suite 500, Washington, DC 20005.

NEW LIFE INSTITUTE

I. U. Willets Road, Albertson, NY 11507

Promotes part-time and temporary employment for persons over the age of 55.

SENIOR ADVOCATES INTERNATIONAL

1825 K St., N. W., Washington, DC 20006

Provides products and services to the elderly at reduced cost and acts as an advocate in general.

Periodical: Senior Advocate (bimonthly).

SOCIAL SECURITY ADMINISTRATION, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

6401 Security Blvd., Baltimore, MD 21235

Administers Medicare, Retirement and Survivors Insurance, and Supplemental Security Income.

TASK FORCE ON PROBLEMS OF AGING PSYCHIATRISTS

Council on Research and Development of the American Psychiatric Association

1700 18th St., N. W., Washington, DC 20007

The task force studies problems of aging members of the American Psychiatric Association.

UNITED STATES HOUSE OF REPRESENTATIVES SELECT COMMITTEE ON AGING

U.S. House of Representatives, Washington, DC 20515

The Select Committee handles House legislation, holds hearings, and issues reports on the needs of the aging.

UNITED STATES SENATE LABOR AND PUBLIC WELFARE COMMITTEE, SUBCOMMITTEE ON AGING

New Senate Office Bldg., Washington, DC 20510

This subcommittee has jurisdiction over the Older Americans Act.

UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

New Senate Office Bldg., Washington, DC 20510

The special committee makes recommendations to the Senate on problems of the aging.

VACATIONS FOR AGING AND SENIOR CENTERS ASSOCIATION

225 Park Ave. S., New York, NY 10003

Vacations raises funds to subsidize organization camps that serve the elderly to provide costs for those who cannot afford the established rates.

VETERANS ADMINISTRATION

810 Vermont Ave., N. W., Washington, DC 20420

Administers all programs concerning the veteran, many of whom are elderly.

WESTERN GERONTOLOGICAL ASSOCIATION

785 Market St., Rm. 616, San Francisco, CA 94103

A regional group with a national attendance at its conference.

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